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ABSTRACT

Begun in October 1972 as a result and demonstration project, the Alternative to Foster Care Program (ATFCP) grew out of the concern in the Seattle American Indian community over the separation of Indian parents from their children in foster care. ATFCP was to explore the development of means by which Native American families, faced with the threat of child separation, could be assisted in maintaining custody of their children. A residential treatment and referral program, ATFCP consisted of two interlinked program components: residential and outreach. Originally designed to provide families with behavioral techniques of child and self-management, the ATFCP shifted to offering community education, legal and welfare advocacy, and assistance with concrete service needs. Staff were trained toward a case-management and crisis-intervention approach. The staff acted as case coordinators, assessing the individual families' goals and needs and attempting to meet them through appropriate referrals or advocacy. Covering the period from October 1972 through December 1974, this report discusses: the need for an alternative to foster care for Native Americans; program start-up and formation difficulties--changes in operating goals and objectives, assumptive errors regarding needs, and staff training, morale, and turnover; methods of data collection for evaluation; the ATFCP's components; and program costs. (NQ)

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EVALUATION REPORT:
ALTERNATIVE TO FOSTER CARE

Prepared by

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Acting Principal Investigator

Submitted to

Office of Child Development
Department of Health, Education and Welfare

June 25, 1975

RC009083

FORWARD

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Virgil James	Outreach Worker
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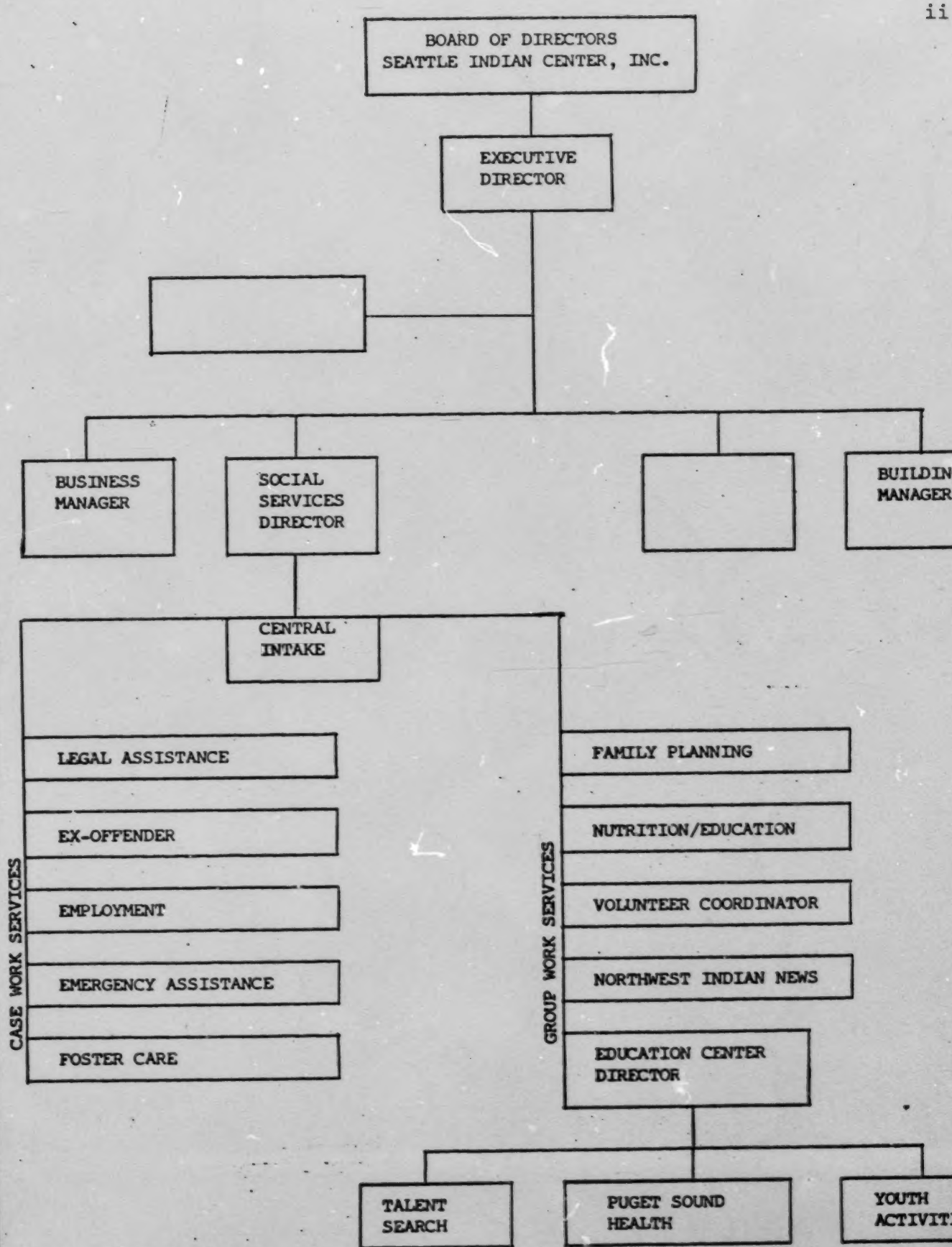
Alternative to Foster Care Grant Number: OCD-CB-397-C2

The structural relationship of the Alternative to Foster Care Program and the Seattle Indian Center and its several sub-programs is shown on page ii.

TABLE OF CONTENTS

INTRODUCTION		
CHAPTER I	THE NEED FOR AN ALTERNATIVE TO FOSTER CARE FOR NATIVE AMERICANS.	1
	Goals and Objectives	
CHAPTER II	PROGRAM START-UP AND FORMATIVE DIFFICULTIES. .	14
	Changes in Operating Goals and Objectives and Assumptive Errors Regarding Needs	
	Other Formative Difficulties	
	Staff Training, Morale and Turnover	
CHAPTER III	METHODS OF DATA COLLECTION FOR EVALUATION. .	33
	A Descriptive Profile of Native American Family Residents in the Program	
CHAPTER IV	COMPONENTS OF THE ALTERNATIVE TO FOSTER CARE PROGRAM.	47
	Measures of Effectiveness	
CHAPTER V	PROGRAM COSTS	79
CHAPTER VI	SUMMARY AND RECOMMENDATIONS	85
Appendix A	Instruments, forms and flyers	
Appendix B	Job Descriptions	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INTRODUCTION

The Alternative to Foster Care Program (ATFCP) began in October, 1972 as a research and demonstration project funded by the Office of Child Development, Department of Health, Education, and Welfare. The intent of the program was to explore the development of means by which Native American families, faced with the threat of child separation, could be assisted in maintaining custody of their children.

Since its beginning, ATFCP has been a residential treatment and referral program. The program has been housed in an eleven-unit apartment building in a low-income housing project in the south part of the city of Seattle. Staff offices have occupied one apartment unit. The other apartments have, until recently, been used to house client families in residence at ATFCP. In December of 1974, one apartment unit was established as a day pre-school for children of families in residence. ATFCP began operating as a residential facility in January, 1973 under OCD funding which through December, 1974. This report covers the period from October 1972 through December, 1974.

CHAPTER I

THE NEED FOR AN ALTERNATIVE TO FOSTER CARE FOR NATIVE AMERICANS

Rationale for the Program

The ATFCP originated from the concern of Native American community leaders in the Seattle area regarding the large numbe of NA[1] children who had been separated from their natural paren The concern grew out of impressions gathered over the years by persons that was not derived from systematic problem assessment Rates of child separation among NA peoples were considered high At the time when this concern grew into the development of the proposal, there were no raw data specific to NA's concerning th incidence of child separation. Studies of other underprivelieg groups and their experiences with foster care suggested, howeve that such groups face a higher risk of child separation than mo privelieged groups (Phillips, et. al., 1971; Neane and Matheso 1970). Moreover, NA's appear to be especially vulnerable to ch separation (Neane and Matheson, 1970). The concerns of commun leaders proved to be well founded. Data accumulated over the of the ATFCP indicate that child/parent separation does occur NA's with alarming frequency.

Also, simple removal of NA children from their homes do not necessarily mean that the natural parents of separated chi

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[1]The initials NA will be used in this report to designa Native Americans, a more inclusive term than American Indian.

receive much help in learning means of averting future child separation or in regaining custody of placed children (Donadel 1969). Most critically, in most instances, little is done to assist the NA family avert child separation in the first place and Matheson, 1970).

Due to the general lack of services available to NA nat parents to regain custody of their children and avert future c separation, the temporary function of foster care as an emerge step to protect children with plans to return children to pare custody is, in the majority of cases, an exception.

In the case of N.A. children, as well as other ethnic-minority children, there is the additional factor of the possi negative effects of placing the ethnic-minority child into a w foster-care home. Such placements, regardless of their qualit pose serious questions regarding the degree of ethnic-identifi tion possible for children so placed, and the effect of ethnic identification on general identity formation (Slater and Allbr 1972; Palmer, 1971).

From data available from a survey of N.A. children pla in foster care or other institutional placement in the State Washington conducted in 1974 the following statistics were ob

At the time of the survey some 567 N.A. children were placed after separation from their natural parents. Of those there was placement information available for 159 children. these, 114 were placed in non-Indian homes. Thus 72% of case which the ethnicity of foster parents was recorded involved t placement of N.A. children in non-N.A. foster care homes. Th data also indicate a high rate of serial placements. Of the

children for whom appropriate information was available the following figure indicates the number of serial placements:

Number of Placements	Children	Percent[1]
1	28	19
2	48	32
3	22	15
4	16	11
5-8	34	23
9 (plus)	2	1
	150	101

[1]Percentages do not add to 100 % due to rounding off.

Serial placements are an index of the degree to which care serves as a temporary means of relieving family distress protecting children from abuse, neglect, abandonment or other parental norm-violative behaviors or becomes, overtime, a lon term and semi-permanent disposition of children (Maas, 1969; and Ehlert, 1971). The data suggest that some 50% of N.A. ch for whom information is avialble, experience multiple placeme three or more foster care homes! In addition to the implic of this statistic in terms of the positive identity formation N.A. children in drift, it also serves as eloquent corroborat the lack of effective services available to N.A. families in assisting them to regain custody and prevent further child separation.

Unfortunately the length-of-stay information necessary an adequate analysis of the problem of serial placements was impossible to obtain.[1] Similarly, useful information regardi

[1]Survey data were obtained from the central records of the St of Washington-Department of Social and Health Services. Inc tencies in numbers reflects the current state of record keep Information on some indices was available from certain local while unavailable from others.

reasons for child separation were not available.

Serial placements in non-N.A. foster homes can be expec to compromise the ability of N.A. children, experiencing seria placements, to develop positive self-identities as Native Americans. With the deficit of information available concerni the effects of placing N.A. children in white foster homees, a conclusions drawn are obviously speculative. Other data sugge however, that removal of N.A. children from their natural par with relocation to culturally alien environments has serious cations for identity development. For example, identity conf has been demonstrated to be a result of removal of N.A. child from their natural parents for educational purposes (Bayne, 1 Reno, 1967 and Hobard, 1968). A similar situation may, in fa exist for N.A. children placed in culturally alien homes with standards of conduct and other socio-cultural values quite different from those experienced in their natural homes and c

Exposure to changing standards of prescriptive and pro scriptive values may lead to what Krush describes as psycho-s nomadisim, (Krush, et al, 1966) in which the superficial lear of such values may result in behavioral confusion since behav confusion since behaviors tend to be matched to discrete situ pressures with no particular, enduring across-situation stand This problem may be especially acute for children who are old the time of first placement and who have had more time for wi culture socialization. Although one writer has suggested tha time with natural parents is a good predictor of successful f care placement outcome (Palmer, 1971), this argument does not necessarily include the variable of cultural differences.

Another problem of foster care placement, alluded to is the lack of services available to parents once separatio occurred. The lack of such services does little to assist N.A. parent, who has experienced child separation, to learn and more adaptive means of coping in what often is an unfam urban environment.

Data accumulated over the course of the ATFCP's oper indicates that the majority of participating families came reservation backgrounds:

N=26 families	Reservation	Urban
	17 = 65%	9 = 35%

The criteria used for defining reservation verus urb ground were as follows:

1. Either self-definition: Client head of household defin self as a reservation person.
2. Use of the four-year criterion: Program staff arbitrar used a four year period as a standard. This is, if not defined, and the client head of household had resided i urban area for more four years the individual was consi urbanized.

The pressures of urban adjustment may be one of seve factors associated with the high rate of drinking as a prob at the intake among families admitted to the ATFCP. In ess agreement with the position articulated by Graves (Graves, the experience of the staff of the ATFCP has been that drin serves as a means of coping with feelings of personal failu inadequacy by permitting adults and drinking younsters at I temporary escape from a punishing day-to-day reality. Depr most instances of close friends and kin by the choice to re to the urban enviornment, many of the N.A. family heads who been in residence at the ATFCP, seem to use alcohol as both of escaping pressures while, at the same time, providing a

of socializing with other N.A. persons. The specific impl
of the reservation-urban transition for various behaviors
N.A. peoples are unknown to a large degree. To a great ex
with the exception of a few studies (for example: Price, 1
Ablon, 1964, and Leon and Martin, 1970) the urban Native A
has been ignored by social scientists (Bahr, 1972).

In the absence of information regarding the situati
urban Native Americans in relation to child separation and
social problems, the developers of the ATFCP were forced t
some assumptions about target clientele and their difficul
leading to child separation. In a survey of the foster ca
literature only one study was discovered which contained a
of substance regarding N.A. peoples and child separation.[1]

One of the implicit research functions addressed by
was the description of N.A. families which were at risk of
children to foster care placement.

GOALS AND OBJECTIVES OF THE ATFCP

The goals and objectives of the ATFCP, as original
posed, were couched in the context of serveral questions:

1. Are dysfunctional parents able to become adequate par
through supervised re-patterning of parenting behavio

2. What are the problems associated with having dysfunct
parents engaging in therapeutic group activities whil
in close approximation to one another?

3. What are the problems in supervising dysfunctional pa
implementing good child care routines?

4. What are the benefits to be derived from enabling par
achieve a more functional level of adjustment while a
separation from their children?

As the language of the research questions, listed
suggests problems of definition of dependent variables fo

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[1] The much referred to study by Neane and Matheson in 197
British Columbia, Canada.

establishing outcome measures have been enormous. Originally a dysfunctional family was defined as: "an Indian family which has been referred to the programs by the Washington State Department of Children and Family Services because the decision has either been made or is impending to place its children in foster care." While this definition has the virtue of parsimony it did not anticipate adequately the types of families which would be coming to the ATFCP--(see chapter on assumptive errors for futher information on this difficulty). Similarly, functional level of adjustment was originally defined as "that level of performance of parenting which is sufficient in the judgement of the Director to restore custody of the children to the parent in an independent living situation." As will become clear in Chapter IV, due to a combination of factors, many families were not terminated on the basis of achieving a satisfactory parenting level but because their continued presence was damaging to the program or promised no further benefit to the family.

Given the experience of the ATFCP, many of the questions originally raised must be considered naive to the extreme. Perhaps the crux of the problem lies in the problem of defining not adequacy of parenting but under what conditions. For the majority of N.A. families which have participated at the ATFCP parenting, as such, was not a problem. There were few requests for assistance in child management. As will be shown later in this report, the major difficulty of the majority of clients was various behaviors, including parenting, under the influence of alcohol. Thus, re-patterning of parenting behavior necessitated treatment of the at-risk parent for problems of alcohol-abuse in the majority

of cases. With the exception of question 4 of the objectives, the other three research questions were all contingent for an answer on the ability of the ATFCP to either provide by the activity of its own staff or by referral to an alcohol treatment program, assistance to the participating families in learning to control alcohol consumption. As the data reported in Chapter IV (on status of residents at time of termination) indicate, the ATFCP has been unsuccessful in a number of cases around alcohol management treatment.

Question 4 of the objectives, is best answered not in terms of a measure of functional level of adjustment but simply in the ability of the family to remain together as a unit. As the data contained in this report indicate, many of the families at time of admission had already lost their children to placement and desired to have the family reconstituted. The avoidance of further separation from their children was a common goal of families which had had children separated. For other families, the prevention of child separation was a major goal. In all cases maintenance of the family unit was a goal which, in its accomplishment, provided its own benefits. Unfortunately in several cases the desire to maintain the family unit or reconstitute the family unit did not militate against abandoning the children to the care of the program staff. This aspect of termination is detailed in Chapter IV.

Perhaps the most compelling benefit which could obtain for the N.A. family heads in the ATFCP was the mere fact that they could be helped to regain or maintain custody of their children by staff who did not feel that the parents were social deviants. For persons who may feel inadequate there may be a no-more compelling

reinforcement of this feeling than to have their children taken away. Especially for people originating in cultures in which the importance of family was and is paramount.

Goals and Objectives

The goals and objectives listed here are taken verbatim from the original grant proposal. They have served as guideline's for the programs' actual operation. From time-to-time, as program experience has dictated, the staff have altered the original goals and objectives. Those changes will be enumerated subsequent to listing the original goals and objectives.

Goals

1. To preserve the original family unit of Seattle Indian families threatened with separation of parents from children because of the parent's having provided inadequate child care, specifically:

   1. a. To maintain supervised living situations with the necessary supprotive services for at least ten (10) Indian families, as an alternative to separation or as a preventive to probably separation.

2. To enable these Seattle Indian children to receive adequate child care.

   2.a. To directly deliver on a day-to-day basis adequate child care to twenty (20) children who will be in constant contact with staff with foster care capabilities.

   2.b. To refer these twenty children to day care homes in the event that their parents work or attend training, and to establish and operate an in-house baby sitting service run by parents.

   2.c. To directly provide or arrange for supportive services for at least these twenty children--medical, dental, counseling and remedial education.

3. To improve the capability of these parents to be better providers for their children and to lead more productive satisfying lives.

   3.a. To provide day-to-day supervised instruction using staff with foster care capabilities, in basic child care for

at least ten Indian parents in the innovative living situation.

3.b. To conduct formal courses and workshops for at least ten parents in the area of home economics, budgeting, parent-child relationships, alcoholism, family planning and child growth and development.

3.c. To individually counsel at least ten Indian parents in the problems of their individual lives, such as problems with their children, alcoholism, etc.

3.d. To instruct these ten Indian parents in the basic skills of managing their own behavior, and that of their children.

3.e. To arrange, where applicable, for education, job training, job placement and vocational counseling for at least these ten Indian parents, and to arrange for the necessary supportive services, such as transportation, supplies, etc.

4. To strengthen the capability of at least these ten Indian families to establish their individual Indian identities and to function within the context of the non-Indian urban community by heightening their awareness of past and present Indian culture.

4.a. To maintain contact for at least these ten families with Indian ways by placing them in an apartment living situation with other Indians, staffed and serviced primarily by other Indians and Indian programs.

4.b. To refer at least 10 Indian families to services and enrichment programs for Indians in the Seattle area.

4.c. To provide educational experiences (classroom individual tutoring, field trips, social and cultural exchanges) for at least these ten Indian families which will reinforce being Indian while reducing fear and confusion when dealing with the non-Indian urban setting.

Objectives

Objective 1: To preserve the original family unit of these Seattle Indian families threatened in varying degrees with a foster care situation which would provide for the separation of parent(s) and children.

1.a. Set up advisory board composed of representatives for low-income Indian families, public and private agencies, parents who have lost their children to foster homes, the legal system,

Indian organizations and institutions of higher learning whose function will be to advise on policy for the Group Home Alternative to Existing Foster Care.

1.b. Hire staff consisting of program director, one resident supervisor family, two paraprofessional and a clerk-typist who will work 1/2 time. Preference will be given to Indian applicants.

1.c. The Director, in consultation with technical advisors will design the necessary recording data for evaluative purposes.

1.d. Locate a suitable apartment facility.

1.e. Locate necessary furnishing if they are not provided by the landlord or possessed by the famili in the program.

1.f. The advisory board will make recommendations for in-house rules and procedures for daily operatio of the apartment facilities.

1.g. Determine training needs and train professional and paraprofessional staff.

1.h. In cooperation with the Department of Social and Health Services and the Children's Protective Services will determine qualifications, recruit, screen, and select at least ten (10) families to participate in this program after briefing th candidates on the purposes, rules and procedures of the program. As families leave the program this process will be repeated.

1.i. Conduct weekly progress report sessions with staff and clients as a group and as individuals.

1.j. Deliver and make available supportive services to the Indian families (see activities for Objectives #2, 3, and 4).

Objective 2: Provide child care.

2.a. Professional and Paraprofessional staff will provide direct child care to the children whose families are enrolled in this program on an ongoing basis when it is demonstrated that adequ care is lacking.

2.b. Such activities as are necessary to insure that the group home meets federal child care standard will be carried out by the staff, even though the group home is not designed to be a day-care center in the strict sense.

2.c. Locate day care homes with opening and refer parents whose children need these services.

2.d. Co-ordinate with the Department of Social and Health Services, the Indian Health Clinic, the University of Washington School of Social Work and Special Education, Children's Protective Service and other organizations to directly provide or arrange for the delivery of supporti child welfare services.

Objective 3: Improve the capability of mothers to be better provi and lead more satisfactory lives.

3.a. The program director will train staff in aspect of child care; they all in turn will, by their constant contact, impart this education to the mothers in structured and unstructured sessions

3.b. In cooperation with Department of Social and Health Services, Children and Family Services, Indian Service groups, schools (Seattle Communi College), health care delivers, schedule course and workshops in areas of need demonstrated by mothers; such as parent child relationships, home economics, child-development, etc.

3.c. The program staff and Department of Social and Health Services caseworkers assigned to the families will do cooperative, routine counselin on individual problems on a regular basis.

3.d. Refer mothers to Indian Center services in the areas of manpower training and placement and vocational counseling; directly place mothers i jobs whenever necessary at their request, and arrange for training whenever necessary.
--The program staff will provide supportive counseling.
--The program staff will arrange for materials, funds, etc., necessary for individual mothers to pursue career development.

Objective 4: Strengthen Seattle Indian capability to establish se identity and to function in an urban setting.

4.a. The process involved in accomplishing Objectiv will also accomplish Objective 4.

4.b. To program staff, Department of Social and Heal Services and the advisory board, working cooper tively, will refer the Indian families to Seattle's Indian Services and enrichment progra and will accompany the Indians individually or groups to these services and programs.

4.c. Staff will plan a program of field trips and other enrichment experiences for the participating families, based on desires and needs expressed by these families.

The original goals and objectives of the ATFCP are listed to bo inform the reader of the scope of the original proposal and to forewarn the reader that many of the objectives og the ATFCP have proven to be exquisitely elusive of achievement. For example, while a community board was briefly constituted along the lines dictated by the original proposal, it soon ceased to be an importan component of the ATFCP's operation simply as a result of the lack of any useful function of such a board. Similarly, while placing mothers in jobs on request is a meritorious goal, it has proven difficult to achieve due to the lack of saleable skills among the client mothers and the depressed job market in the area.

As the following chapter indicates, there were considerable difficulties in operating the ATFCP wholly within the guidelines set forth above.

CHAPTER II

PROGRAM START-UP AND FORMATIVE DIFFICULTIES

Office of Child Development, Department of HEW, monies were made available for program start-up and staff development in October, 1972. At that time a Project Director - Principal Investigator was hired. During the same period a treatment consultant was hired (the author of this report) to assist in staff training. In the following month, after screening candidates, a full-time child care worker and two part-time family workers were hired. Given the original assumptions of the ATFCP, staff training was begun in methods of behavior modification with adults and children. These sessions centered around parenting difficulties. The original staff was involved in a six-week "course" in behavioral assessment and application of reinforcement principals to family difficulties. Concomitant with this activity, a search was begun for an appropriate residence facility to house the ATFCP. Most of this activity was the responsibility of the program director - principal investigator and the newly-hired staff. After considerable searching and repeated dissapointment[1] a suitable apartment unit was located in the south part of Seattle.

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[1]Many rental agencies and landlords quickly lost interest in renting a suitable facility when they discovered, in the process of negotiation, that up to ten Native American families at one time might be in residence.

The apartment facility which was chosen was one of a multitu of similar buildings in a low-cost housing project. Needless to say, the building itself was run-down and needed considerable pa ing and other repairs to make the units livable. Arrangements w made for the painting and repairs with the management of the hou project with the work being done through the combined efforts o staff and volunteers.

Meanwhile, staff time was spent in contacting the Washington State DSHS and other relevant agencies to find cases which were eligible under ATFCP guidelines. This activity proved to be fut As a new service organization, the ATFCP had extreme difficulty developing credibility among agencies with access to N. A. famil facing the threat of child separation. As the months went by, more and more time was being spent in casefinding activity until finally, a case was referred to the ATFCP. The referred cases d not meet the guidelines for eligibility established under the co tract with OCD. The first client family in the program consiste of a single woman who desired to regain custody of her children had already been placed in foster care. She was prevented from gaining custody due to being a diagnosed schizophrenic. Althou the staff realized that admission of this individual was not in formity with program guidelines, the lack of eligible clientele prompted the staff to admit the client.

With the admission of the ATFCP's first client it became ap parent that the stated goals of the client were disparate from expectations of the staff. (This problem will be covered in de under Changes in Operating Goals and Assumptive Errors, below).

Although referrals were few and far between, the ATFCP staf was able to admit several families by the early part of 1973 wh by and large, approximated the program guidelines.

Changes in Operating Goals and Objectives and Assumptive Errors Regarding Needs

Over the course of the ATFCP's development it has become cl that several major assumptive errors were made in the original formulation of the ATFCP and its operations. As a quick perusa of the goals and objectives of the program will evidence, the original conception of the ATFCP was highly child and self-man ment centered. That is, the assumption was made that families participating in the ATFCP would be in need of re-parenting tr ing due to the expectation that the majority of child separati occurred because of a behavioral deficit in the areas of child self management. The following data suggest this assumption h proven to be only partially true from the perspective of Nativ American parents.

Goals of Clients Entering the ATFCP

The following goals are displayed in twelve exhaustive cat and represent the personal goals of the 26 families which have in residence at the ATFCP.

Goals*	Number of requests	%
Assistance in alcohol management	23	
Assistance in regaining custody	17	
Assistance in marital or conjugal relations	5	
Assistance in obtaining or finishing education	5	
Assistance in learning child management skills	5	

Goals	Number of requests	% of
Assistance with legal problems	5	
Assistance with financial problems	4	
Assistance with housing problems	2	
Assistance with emergency food needs	1	
Assistance in obtaining child care	1	

* These are goals specified at the beginning of treatment at ATFCP and do not necessarily exclude others which may have eme over the course of treatment.

Over time, the original staff had to re-orient themselves a child centered and adult re-parenting program operation appr to one which was largely centered on supportive-directive coun and referral work to assist families in obtaining basic needed services.

Another assumption which has proven to be problematic was expectation, implicit in the original proposal, that the scena eventuating in the threat of child separation was a gradual on That is, the family will be known to social agency personnel, information available, to be malfeasant or potentially malfeas in some aspect of parenting. Conditions were expected to dete rate until such a time when child separation become necessary ensure the continued health and welfare of the child.

Due to this assumption, the ATFCP was originally intended serve families before child separation occurred. Unfortunatel this has proven to be only partially true of the families refe to the ATFCP. As the following data indicate, a majority of t families admitted to the ATFCP have had their children separat

some time previous to admission to the program.

Families	Child(ren) in Foster care at the time of admission	Child(ren) parent
N = 26	17 families = 65%	9 families

Because of the large proportion of families which had chil already separated, it has developed that a large amount of residential program staff activity has gone into assisting the family to regain separated children. Admissions to the progra have varied but the majority of planned admissions have been referrals from the offices of the Department of Social and Hea Services-State of Washington and have occurred after child sep tion. The following data describe the number of planned, plan emergency, and emergency cases which have been admitted to the

Definitions:

1. planned admission = discussions with referr person(s) and the client head of household regarding the ATFCP, its goals and activiti The availability of some lead time permits reach work and visitation prior to admissio of the family.

2. planned-emergency admission = discusssions referring person(s) and the client head of hold regarding the ATFCP, its goals and act but there exists some emerging difficulty w makes a decision to admit urgent.

3. emergency = there is clear danger to client family or severe deprivation conditions war immediate admission.

N=26 families

Referral Source:	Planned	Planned Emergency	Em
D.S.H.S n=15	11	4	
Catholic Children's Service n=3	2	-	
Indian Health Service n-2	-	1	

Referral Source:		Planned	Planned Emergency	Em
Tribal referral	n=2	2	-	
SIAP	n=1	1	-	
		18 (69%)	5 (19%)	

As the data indicate, the majority of families admitted ATFCP were able to meet with program staff and referring per to arrange the details of admission. Many of the planned re originated in a DSHS agency. For the majority of DSHS refer and admitted families, reconstitution of the family (regaini custody of separated children) was a primary goal. It shoul noted that this goal was shared by the majority of families had had children separated prior to admission to the ATFCP. referrals are singled out only to indicate the difficulty wh obtained, over time of program operation, in receiving famil referrals from the DSHS offices before child separation has

Yet another assumptive error is related to the needs ass errors previously mentioned, and concerns the etiology of ch separation among Native American families. As is obvious fr original proposal, alcohol was not a major expected problem information aggregated over the course of the program's oper indicates that in the vast majority of families admitted to ATFCP, problems with alcohol management have played a centra in the situations leading to either the threat of or child

> Of the 26 families for which information is available, problems in self-management related to alcohol accounted for 88% of admitted families. Abuse and neglect account for 83% of families admitted to the ATF Abandonment accounts for another 36% of admitted famili (The percentage overlap is a result of interacting inte acting categories, e.g. neglect resulting from abandonm

The realization that alcohol management difficulties w
be the major reason for child separation among admitted fa
necessitated a change in treatment orientation among the s
From a treatment orientation geared to remediation of chil
ment difficulties, the treatment approach of the ATFCP cha
with time to one of supportive counseling and attention to
crete needs such as obtaining welfare benefits, finding cl
and assisting families with medical[1] and legal difficulties

Early in the life of the program, some staff work was
targeted on the drinking behaviors of client heads of hous
Unfortunately the amount of time necessary to establish an
individual treatment programs for drinking problems proved
impossible for the staff to provide as new client families
into the program. Moreover, the treatment of alcohol prob
not a strength of either of the professional staff involve
program at that time[2] or the paraprofessional staff. As a
a program decision was made to refer clients in the reside
program with alcohol management problems to the Seattle In
Alcoholism Program located in the Seattle Indian Center.
staff trained in alcohol treatment the SIAP offered more
service to the clientele of the ATFCP than the residential
staff. The staff of the ATFCP acted as adjunctive treatme
personnel reinforcing the efforts of the SIAP treatment pr

Lastly, the assumption was made that the ATFCP would
admitting families with considerable ambivalence regardin
ethnic heritage. Many studies have indicated that cultura
marginality is a predictable corollary of conflict betwee

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[1] Medical hereafter includes dental service.

[2] Director-Principal Investigator and Program Consultant

differing cultures. In addition, cultural marginality has played a relatively major role as an explanatory factor in theories attempting to explain N.A. drinking behavior. The collected experience of the ATFCP staff suggests that in the majority of cases admitted, ethnic-identification was positive and reflected an interest in various N.A. traditional cultures. As a consequence of the staffs' impressions of the client group there has been less emphasis placed on cultural support programs than originally anticipated.

In summary there have been major changes in the operations of the ATFCP derived from accumulating experience. From a program originally designed to provide families with behavioral techniques of child and self-management the ATFCP has shifted to offerring community education, legal and welfare advocacy and assistance with concrete service needs. There has been a corresponding shift in training of staff towards a case-management and crisis-intervention approach. The case-management approach warrants further description. The residential program staff have acted as case coordinators, assessing the individual families goals and needs and attempting to meet them through appropriate referrals or advocacy. More importantly, residential program staff have acted as protective agents to shield client families from various environmental pressures. As will become clear in the section on residential program activities (Chapter IV) many of the families, on admission, were being encountered by various personnel of social agencies. Program staff could "run interference" for resident families while working with the family heads toward an effective program to reduce such demands. Although such an

approach is desirable to allow a family an opportunity to adjust to new surroundings while mobilizing its resources for new activity, it has proven to be a highly labor intensive treatment approach.

Other formative difficulties

Beyond the changes (mentioned above) resulting from assumptive errors, the ATFCP has had other difficulties. From the opening of the doors of the ATFCP in January of 1973 through the middle of 1974 there has been a major problem in obtaining referrals appropriate to the program's guidelines. Eligibility criteria for residence in the ATFCP were established in the original proposal:

1. The family included children or a child under six years of age. It was assumed that early intervention with dysfunctional families would maximize their ability to use whatever therapeutic services the residential program could offer. The additional assumption was made that families having children or a child under six would prove to be younger and more amendable to behavior change efforts. Also, there was a concern with assisting families to preventive medical services as well as providing an opportunity to identify any children with learning disabilities.

2. The family voluntarily chose participation in the ATFCP in preference to foster care or other child placement. The imposition of a voluntary participation criterion was to ensure that resident families were motivated to participate in the activities of the program.

3. The family heads agreed to remain in the program for a minimum of three months. It was assumed that many of the child and

self management difficulties believed to be responsible for the child(ren)'s threatened status could be effectively changed in that period of time. In addition, it was believed that any considerably longer period of residence would result in injurious dependency of families on the staff. Again the assumptive errors around clients' needs informed this optimistic expectation. Accumulating evidence that the majority of families coming to the ATFCP were in need of longer term assistance obviated this guideline.

4. The family heads would agree to permit ATFCP staff to obtain client records from appropriate Department of Social and Health Services (DSHS) agencies as well as other community services. Because of the lack of comparison data available in the literature on foster care specific to N.A.'s, it was necessary to obtain as much historical information regarding the client families' previous experiences with child placing agencies as possible. Such information would have provided a means to at least gain some perspective on the etiology of child separations among the families in the ATFCP.

This privilege was obtained through the routine request of clients to sign a release-of-information form required by the State of Washington agencies. Unfortunately, in most cases such information was not forthcoming from State agencies. Either through inability of the assigned caseworker to find the client families records or through difficulty in enlisting the cooperation of DSHS personnel with primary responsibility for the case, in the majority of cases this information was unavailable. A third reason for the lack of historical information was the small number

of families for whom the current situation resulting in a threat to family continuity was the "first offense." For such families and other for whom information was not available, the staff of ATFCP had to rely upon client's memories and willingness to divulge information regarding previous child separations, or family difficulties.

5. It was assumed, as in criterion #2, that voluntary participation in structured activities promised a better climate within the residential program due to the lack of need for program sanctions or coercive measures to ensure participation. As ATFCP developed, this assumption proved to be naive. Participation in certain types of structured activities has continued to be a problem. Especially problematic were the therapeutic groups which were originally developed to permit N.A. family heads to share experiences and to learn from one another. For reasons which may, in part, be related to cultural differences in norms regarding self-disclosing behavior, these group sessions were extremely poorly attended and were abandoned in favor of more task-focused group activity.

In light of these eligibility criteria several related problem areas emerged which were to make the formative period of the ATFCP extremely difficult. The problem of obtaining appropriate referrals has already been touched upon, but requires further elaboration for an adequate picture of the early months of ATFCP's operation. Repeated contacts whether personal or by mail, telephone, and broadcast mailings of descriptive brochures served to no avail in obtaining referrals from child placing agencies. This

does not mean that referrals were entirely lacking. Program data indicate that in the first quarter of 1973 (January, February, March) there were 16 referrals received at ATFCP representing some 47 individuals.

Referrals for first quarter, 1973, by month:

Month	Referrals
January	5
February	4
March	7

Half (8) of the referrals were made by DSHS personnel. The remaining half were made by personnel of other organizations in the Native American community or were self-referrals. The problem, then, was not an absolute lack of referrals but one of small numbers containing a large proportion of ineligible families. The major eligibility constraints were that the family should include a child or children under age six and the condition that the family should be intact at the time of admission. Data available for the first quarter indicate that while many families had a child or children under six years of age, in the majority of cases some or all of the children had already been separated at time of the family's application to the program. Eleven of the referrals from that first quarter were requests by parents for assistance in re-establishing custody of separated children. Although these first quarter data are used for illustrative purposes only, data from subsequent quarters are fairly consistent with those data.

In response to the problem of obtaining appropriate referrals from child placing agencies, ATFCP staff appealed for DSHS administrative intervention to determine whether a directive from the

regional administrator would be of assistance in obtaining referrals from DSHS agencies. Such a directive specifying mode of referral, case transferring, and maintaining contact with the client family and the staff of ATFCP was graciously sent to all local offices by the regional administrator in December of 1973. Program data indicate a slight increase in total referrals subsequent to this administrative directive, but no appreciable increase in referrals deriving from State of Washington child placing agencies.

In the first year of program operation it became clear that intact families at time of admission were going to be the exceptions among families referred to ATFCP. Because of this, and the reality that the staff had already admitted some parents who had had children separated at the time of entry into the program, the staff sought a change in operating procedure which permitted ATFCP to admit families for whom reconstitution of the family unit was a goal. This change in eligibility criteria was obtained through the cooperation of the Office of Child Development and its regiona officials who were very understanding toward the client recruitment problems of the ATFCP. As a result of that change, available referrals during any particular subsequent quarter were sufficient to ensure the program an admissions pool.

In the administrative directive of December, 1973, a caseworke in the DSHS office serving the area in which the ATFCP was located was designated liaison person to the program. This role has been of enormous value in coordinating the activities of ATFCP staff and DSHS personnel.

Staff Training, staff morale, and turnover

Beginning with the "startup" period, training was provided to The original staff of the program in behavorial methods of assessment and treatment. Staff training has continued to be an ongoing component of ATFCP.

Various staff members have been provided the following training programs during the 2 1/2 years covered by this report.

1. Startup-training in behavior methods of assessment and treatment.
2. Methods of assessment for group and individual counseling.
3. Methods of crisis intervention.
4. Family counseling training.
5. Northwest Behavior Therapy workshop.
6. Child-Abuse and Neglect Act workshop.
7. Basic interviewing skills.
8. Training in the operations and functions of child Protective Services (for both staff and residents).
9. Group Processes Skills workshop.
10. Department of Social and Health Services workshop.
11. Basic Counseling Skills
12. Family Theraphy workshop
13. Techniques of Working with Distrubed Children-Department of Social and Health Services
14. Human Development and Societal Response

Because all of the staff in positions of direct treatment responsibility[1] have been paraprofessionals with little direct human service experience, the ATFCP has stressed the training aspects of staff development. The majority of staff participated in one or several of the above listed training programs. The list

[1] See chart on page 28 for paraprofessional positions

Staff Position / Years and Months	'72 O/N/D	'73 J/F/M/A/M/J/J/A/S/O/N/D	'74 J/F/M/A/M/J/J/A/S/O/N/D	'75 J/F/M
Director/principal Investigator	Professional worker full-time	Paraprofessional worker full-time		
Program consultant	Professional worker part-time	assumed acting principal investigator role part-time		
Family worker	Paraprofessional part-time	Paraprofessional part-time		
Child care worker	Paraprofessional part-time			
Resident Supervisor family	Paraprofessional also acting as clerk typist: Half-time	Paraprofessional full-time	para. F-T	Role of resident supervisor family rotated among families in res.
Outreach worker		Paraprofessional full-time		Paraprofessional full-time
Outreach worker				Paraprofessional full-time
Day School worker				Paraprofessional full-time
Resident family worker		Paraprofessional full-time		
Worker turnover	Excepting the consultant-acting principal investigator who has been with the program since its inception and the staff hired in December of 1974, the total number of person months worked totals some 103 months. In that time there were 11 different persons in employment either in full-time or part-time positions.			
	The mean number of months worked by an individual worker calculates to approximately 9.4 months.			

is not exhaustive but covers only those with direct service training value. Yet due to high staff turnover the cumulative effects of the training programs made available have not been maximal in terms of improved treatment effectiveness with any one client group.

Given the need, however, in the N.A. community for trained, paraprofessional direct-service workers the opportunity of work employed at the ATFCP to obtain some training will likely have beneficial effect in terms of future N.A. community programs.

The rate of staff turnover appears to be fairly high althou no comparison information is available due to the lack of any program such as the ATFCP, (please see chart on preceding page for turnover display.) During the start-up period confusion regarding the means to accomplish program goals led to under-standable problems of morale among both paraprofessional and pr fessional staff. The sheer expansiveness of the original progr goals resulted in the morale problem which, in turn, fed back into the problems of developing a viable program model. More critically, staff turnover occurred with sufficient frequency t make staff training difficult. As mentioned earlier, although most staff engaged in some training activity, no individual sta person profited from the whole array of training activities.

As was mentioned earlier on the section pertaining to assump errors, a major training difficulty centered around the assumptio that the majority of client adults would be seeking assistance i the management of their children and in learning new methods of parenting. Through perhaps too literal an interpretation of the of the ATFCP set forth in the original proposal, the training of original staff was heavily concentrated on behavior modificatio methods of child management, with much less emphasis on self-man ment procedures. Those which were taught did not include means alcohol treatment since the available techniques were beyond the scope of a paraprofessional staff to render.

As the program developed it became clear that few of the cl families entering the program felt that child management was a h priority goal. Rather, as indicated earlier, the concerns of mo client entering the residential program were centered on assista with alcohol management, regaining custody of children already separated, and assistance in obtaining other forms of basic serv e.g. food and clothing. The situation obtained, then, of having a staff trained to assist families toward goals irrelevant to th families' perceived needs. At first there was considerable doub that this could be the case. Yet with time, staff became increa ingly convinced that the family adults-in-residence were quite caring and adequate parents except during periods of alcohol use when parents seemed to forget to come home to watch over their children, or were negligent of the children's basic needs for fo and hygiene. Even with these domestic problems, the children o the families in residence at ATFCP seemed to be quite emotionall healthy, evidencing few of the nervous or destructive behaviors

one would expect, at least among some of a similarly ge group of non-NA children.

The lack of behavior problems among this group youngster has impressed the staff. Nor was there any indicatio that pare were attempting to conceal child-acting-out behavior from the st

The mismatch between the training of the original staff and goals brought to the program by its client families was the basi of significant problems of staff morale during the first six mon of program operations. During that period, staff were restraine by the use of consultation around cases, but the morale problem continued. It may have been that the original staff had develop expectations regarding the treatment activities at ATFCP which w highly resistant to change. Rather than engaging in therapeutic activities with client adults and families using highly specific reinforcement methods of treatment, the actual work of the staff was increasingly in the direction of case management, resource identification and referral. These activities were considered b original staff to be far less rewarding and considerably more mu than the tasks for which they were hired.

Similarly great emphasis was placed on the research aspects ATFCP in the training of the first staff. Staff persons were tr in methods of treatment goal-setting which permit measurement of outcomes and the use of various individualized designs for monit adult and child behaviors. As ATFCP experienced difficulty in obtaining referrals and as more families moved in, the staff was forced through sheer pressures of time to abandon these approach to research in favor of more traditional case recording methods

As should be clear, the transition to a mode of program oper responsive to the needs of participating families was a slow and difficult one. It was only in the middle of 1973 when a staff changeover occurred and the program found itself very shortstaff that the transition to a routine method of case-management, resc identification and referral with individual supportive-directive counseling occurred. Staff turnover resulted in the program ope ing at certain with very few staff. ATFCP was able to hire a wo study student to do casefinding work for the program for several months, as a means of supplementing the staff. During the perio from January through June, 1974, a graduate student from the Sch of Social Work, University of Washington was placed at the progr on a part-time basis as part of his internship program. Supervi of the student was provided by the program consultant.

After the staff turnover in mid-1973, new staff were routin trained in the use of recording instruments developed for ATFCP, in techniques of goal setting and case evaluation. Ye[illegible] as will noted in the following chapter, case recording has proven to be enormous problem.

Chapter III addresses the empirical problems of ATFCP and th accommodations which were made in the design of the evaluation m

CHAPTER III

METHODS OF DATA COLLECTION

As has been true of many aspects of ATFCP, the techniques originally designed and intended for use in program evaluation changed with increasing experience with the types of worker a necessary for program operation. Moreover, the methods of da collection have had to change with increasing experience by t acting-principal investigator of the value placed on data col activities by staff. Originally data were to be collected on specified behavorial goals of treatment and broken into measu components to permit the evaluation of treatment through comp of change on these measurable indicators. These approaches w gradually abandoned by staff as too time-consuming for routin

More recently (from mid-1973 through program year 1974) staff has been using a more traditional method of data keepin worker has been instructed to work with client family heads t establishing clear objectives of treatment relevant to the cl needs. In addition, the worker was instructed to use an inta form which both requested pertinent historical information an vided the worker with information regarding the client's func Besides the intake forms other data recording forms were deve for use at the ATFCP. Among them are:

1. Personal contact sheets-which were intended for use recording unplanned contact with clients, the subst of the contact and any outcome, for example a refer

2. Interview contact sheets-these were devised to reco regularly scheduled interviews with clients and/or activity such as a visit by the family and worker t welfare office.

3. Project data sheets-this form was developed to both target behaviors and record treatment progress rela specific behavior change programs.

Use of the various data collection instruments has been at best. Available case records vary from relatively comple records to those which contain little information. Attempts program director and acting-principal investigator to assist to improve the quality of recording have not been successful of available case records indicates that much worker activit client behaviors were not recorded systematically.

Perhaps the most critical data problem which plagued th was the lack of systematic follow-up information on client f which had been terminated. A combination of factors seem to responsible for this deficit. High rates of movement by NA made for understandable difficulties in keeping track of the once they left the program. With pressure to attend to the immediately facing them, staff often times did not make foll attempts at specified intervals. The rate of staff turnover in a hesitance of some staff to make contact with a family w the staff person had never worked.

These problems of data collection are obviously not uni the ATFCP (Weiss, 1972). In large part, data collection dif (around measures necessary for program evaluation) may have to the nature of the program. Much of the staff-client cont

unplanned. Contacts tended to be spontaneous and centered on some problems that needed immediate attention. In the face of competing demands to provide direct services (e. g., advising a mother regarding the need to contact a caseworker) or to spend time documenting worker and client activity, the most common worker response to the conflict, evident from the case records, was to provide service and give less attention to documentation.

A major staffing change may have played a large role in the persistence of this data-keeping problem. Originally the program staff included a professional director with research skills who was to supervise the research activities of the staff. Six months into the program's operation, this director was replaced by a paraprofessional worker with little background in research or direct service work.

This change resulted in the lack of a full-time staff supervisor who could assist staff in maintaining case records in a manner which would permit data retrieval on critical measures. Due to this personnel change, the part-time program consultant who had been working with the staff in on-the-job training as well as direct work with a number of the clients, assumed the role of principal investigator as well as program consultant. Consultation with the new program director and staff around the continuing data needs of the program was only moderately sucessful in terms of any change in case recordings.

Yet, even with these difficulties, the ATFCP has been able to collect sufficient data to permit some tentative conclusions to be drawn regarding its effectiveness in assisting families to avert child separation.

Before proceeding to a description of the ATFCP's mode of operation in Chapter IV, descriptive information regarding the client families who have been in residence at ATFCP is presented below to provide a perspective on the client group.

Client Descriptive Information

The majority of families who have been in residence at the ATFCP have been single-parent families.

Number of families: 26

Mother head-of-household: 22 (85%)

Couples: 4 (15%)

Married: 18 (69%)

Separated: 14 (54%)

Divorced: 2 (8%)

Unmarried: 8 (31%)

As these data indicate, 85% of the families who have been in residence were headed by women at the time of admission. In 15% of the cases there was a couple with children. The majority of married women were separated from their husbands although few had obtained a divorce. In several cases, legal assistance in obtaining a divorce was a goal of the head of household while in residence at the program. While in residence, most of the women heads-of-household maintained social contact with boyfriends, ex-husbands, or casual male acquaintances. Such activities were encouraged by staff due to the need of the client adults for other adult companionship. And yet, the ability of the adults in residence to socialize and bring friends into their apartments with the approval of staff had some serious negative side effects.

As one measure of the kinds of relationships which the women were escaping (in some cases by entering ATFCP), the staff attempted to document the incidence of physical abuse to client women by husbands, ex-husbands, and/or boyfriends. These data showed that in 15 cases (58%) some degree of physical abuse was inflicted on the women clients.

These figures were derived largely from client self-report. In an area of considerable sensitivity, the reliability of these data may be questionable. The impressions of the staff indicate that the women clients seriously under-represented the problem. Unfortunately, the staff in several instances had been witness to the effects of such abuse. It serves no purpose to describe such incidences, but it should be known that the severity of such abuse of N. A. women in the ATFCP sample included abuse resulting in hospitalization for broken bones and internal injuries. In all known cases, such abuse was the result of alcohol on the part of the aggressor and/or victim in which anger flared and violence was done to one or several people. In order to protect client women from further abuse, the staff, when requested, assisted several women in obtaining restraining orders to prevent angered men from harming them. In afew cases staff had to physically intercede to protect the women from violence. Such intervention posed a serious threat to the staff members involved, but there were no alternatives. In other cases, police were called to forcibly remove abusive men from the premises. The tragedy that, with women for whom physical abuse was a danger to health, the pattern of drinking resulting in injury from abuse tended to repeat itself. The rate and severity of physical abuse offers grim evidence of one of the seldom-reported by-products of drinking among N. A. women.

Counseling around marital and other relationship problems with men has been a major component of the activity of staff in the program with client women.

Education

The average education of ATFCP parents was 10 years with a range of 3 years of formal education to 13 years. 8 of the 26 family heads had completed high school (31%). Obtaining some skill training or a desire to finish high school was a common goal at time of program entry. Occupation of family-head data indicates that few were skilled:

Skilled	Unskilled
5=19%	21=81%

Skilled workers were defined as people who had been steadily employed for some period of time at a trade. Unskilled workers were defined as having had only occassional employment, if any, at different jobs. The positions considered to be skilled were:

1. Nursy home worker
2. Secretary
3. Hospital Aide
4. Carpenter
5. Paraprofessional counselor

The rest of the family-heads were only periodically employed, if at all. Most reported the most minimal work history in adult years. While married and living together, most women reported that they were dependent on their husbands' incomes and/or public welfare benefits received by the couple. Since separation, the majority of women heads-of-household were dependent on public

welfare payment for survival. In a few instances families moved into the program with no source of income at all. In those cases, staff engaged in welfare advocacy work to enroll the families and/or obtained emergency loans. The following data describe the income source of families at program entry:

	Source of Income	
Families	Public Welfare or no income	Working
26	24 = 92%	3 = 8%[1]

Lack of saleable skills, difficulties with alcohol management, the need to care for small children, inability to maintain a job once employed, and a depressed labor market are but some of the reasons for the high rate of unemployment among the families that have been in residence. Because of the desire of many family heads to find employment, much of staff time was spent in referring clients to employment agencies. With minimal skills, however, and the condition of the labor market these efforts have been largely unsuccessful.

For many of the client families, difficulties of establishing residence, finding work, and developing a means of coping have been exacerbated by pressures resulting from recent rural-urban migration. Seven of the 26 families that have been in residence came into the program directly from reservation life. For the majority of families the reservation experience was the major influence in the families' lives.

Families N = 26	Reservation	Urban
26	17 = 65%	9 = 35%

The recency of many of the families' migration to the urban

[1] Two working fathers; One mother with a part-time job.

environment was a major factor in defining much of the staff activity of the program. Familiarization of family members with urban life was a necessary feature of most treatment programs. A great deal of time was spent in conference with referring caseworkers regarding the possible role of cultural differences in defining adequate parenting. Behaviors which are deemed norm-violative[1] by caseworkers may, in fact, be related to differing norms of child care related to different definitions of childhood competencies. For example, as Minnis has suggested for families in the Fort Hall reservation in Idaho, children are often left with members of the extended family or sometimes simply left alone to fend for themselves while their parents engage in recreational activity (Minnis, 1963).

Definitional problems with standard terms used to describe norm-violative behaviors, (e.g., abuse, neglect and abandonment) by social agency personnel in regards to NA peoples pose significant difficulties in ascertaining the degree of actual harm or potential harm which resulted to the child(ren) in cases in which children had been separated. Of the thirty families for whom such information is available, abuse-neglect and abandonment account for the majority of reasons for child separation. (Additional case histories were obtained from Outreach Program records.) Unfortunately, the lumping together of abuse and neglect and the lack of specificity regarding the condition of children when child separation occurred, or was threatened, greatly confounds the ability to report exactly what had occurred prior to separation.

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[1] Norm-violations are defined, of course, in terms of prevailing patterns of behavior among non-NA peoples.

Reasons for Referral

Families	Abuse - Neglect	Abandonment
N = 30	25 cases = 83%	11 = 36%

Just what constitutes abandonment among NA families is as unclear as the meaning of abuse and neglect. If, as Minnis suggests, children are left alone for a few days with parents fully intending to return, can that behavior be defined as abandonment as opposed to permanent desertion of children? Experience within the ATFCP has indicated that when children are left by parent(s) for an extended period of time others are expected to care for the children until the parent(s) return. This service is reciprocated on need in a fashion which is suggestive of the extended family network described by Minnis. That no blood ties existed did not seem to deter some families in the ATFCP from leaving their children with other families for days at a time. This pattern may be evidence for the portability of traditional ways of mutual child care. That is, these customs are brought into the urban environment but due to lack of parent-substitute persons and differing definitions of conduct, the results often are complaints made by neighbors which result in child separation due to presumed neglect or abandonment. Because these remarks are based on impressionistic data they are, obviously, speculative. But such consequences obtaining for parent <u>may</u> be one of the most tragic results of differing norms of conduct existing between NA cultures and child-protective service personnel. One of the observed ironies, over the course of the ATFCP, is that a small number of NA family heads bewildered by the power of the State to deprive them of their children for various norm-violations when the original intent of the family heads was to seek very tempora

care for their children while they attended to some necessary business. In a few cases children were voluntarily placed in custody with what appears to be the same understanding on the part of the parent as would obtain, had the parent entrusted the child to a friend or neighbor. That is, the relinquishment of children was understood to be temporary and could be undone upon return of the parent(s). When parents requested return of the children and were confronted with visiting caseworkers and various legal difficulties of re-establishing custody, the bewildered family did not know how to proceed and wound up referred to the ATFCP.

Cultural differences do exist, and until social agency personnel are made more aware of their significance, such conflicts of understanding will continue with the effect that many more NA children will be separated from their parents as part of the families struggle to learn new ways in the urban environment.

Again, Minnis observes in the Fort Hall study, that parents seemed to be ambivalent towards their children. While highly nurturant and affectionate toward their children there is little hesitancy in leaving the children or neglecting them. But, as was mentioned earlier, neglect and abandonment are not only putative descriptions of effects on children but assumptions regarding the motivations of parents. It is in the area of presumed motivation that cultural differences in norms of conduct may result in most damage to NA family life due to intervention by social agents.

At the ATFCP there were several instances of parent(s) leaving their children with no adult care arranged. Usually the adult

be on a drinking binge. Because of serious doubts about the nature of the problem, ATFCP staff decided that any form of punishment for such behavior would be self-defeating. The greatest punisher the program could use would have been the removal of the parent(s) children, the very scenario the program was developed to avoid. Rather, every attempt was made to control the rate of such behavio by the use of praise for periods of sobriety and the use of mild punishments, such as expressions of disappointment, when clients drank. The major counseling objective was not to control the soci izing behavior of the client head-of-family, even if this involved the use of alcohol outside the program, but to assist the client in learning to make arrangements for child supervision and care during periods of parental absence.

In discussions with family adults, staff have surmised that f many of the family heads, drinking in the companionship of other adults served as a major form of recreation. Beyond its recreatic value, drinking appears to have provided some negative reinforce- ment by effectively terminating what could be considered an aversi situation in some cases. That is, with demands being made on the parent(s) by children and other adults--including program staff-- and with chronic worries about how to feed, house and clothe thei families, drinking might have served to relieve the stress situat at least for a while, imposed by poverty and social marginality.

The number of children in client families varied from one (5 families) to nine (one family). Not all of the children in a fam were necessarily in residence in the ATFCP since in many cases so or all of the children had already been separated. The average number of children in a family was 3.5 with a median of 3. The

average age of children was 5.78 years with a range from 16 years to two months of age.[1]

Placement History

The families have had varied child placement histories. As was mentioned earlier there was considerable difficulty in gaining clear information from either child-placing personnel or parents regarding the placement history of the family and the situations leading to child separation. However, the staff operating within these data constraints was able to collect sufficient self-report and other data to permit the following table to be presented. Placement data are given as individual child placements. Thus, if six children were removed from a family at one time that would be portrayed as six individual child placements. Within this definition the following data represent basic information regarding placement histories of families at the ATFCP.

Families	Total No. of Placements	Average No. of Placeme
N = 26	113	5.9 per family [2]

Of the 26 families, seven had had no previous child placemen A few had placed children with relatives for brief period of time Placement incidence ranges from a single placement of a child in family to 16 individual child separations for a family. Six fami accounted for fully 67 of the placements included in the 113 tota

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[1] One client was unable to remember the number of children she had borne, the best estimate based on her self-report and other records was 7. In serveral instances mothers were not sure of their childrens' ages.

[2] This average represents the total number of placements divided by the number of families which have had children separated, not the total number of families which have been program participants.

Family	No. of Placements	No. of Separations
a.	9	once
b.	7	twice
c.	10	twice
d.	16	five
e.	15	three
f.	10	twice
6 families	67 or 59% of placements	

Placements recorded here include not only placement in foste care but other child dispositions such as adoption or court-order placement with a relative. As is clear, the majority of families who have participated at the ATFCP have had experience with child separation. Of the 26 families, 10 had experienced multiple separations, nine had only one previous child separation and, as noted earlier, seven had no such experience.

Families	Multiple	Once previous	None previous
N = 26	10 = 38%	9 = 35%	7 = 27%

The total number of families which were experiencing the threat of yet another child separation number 19 (73%) of familie admitted. This percentage of "repeater" families offers sad but compelling evidence for the issue raised in the introductory chapter of this report regarding the lack of services available to parents once child separation has occurred to assist the fami to learn new ways of averting future child separation.

Length of Stay at the ATFCP

Originally families were to stay in residence at the progra approximately ninety days (three months) which was deemed the

minimal time necessary to accomplish what was then considered the likely treatment targets of behavior change programs. Program experience suggests that three months is an inadequate amount of time for a program like ATFCP to accomplish much, given the kinds of problems that families bring to treatment.

> Of 19 families, for whom records are adequate, the total length of stay in the ATFCP has been 2,794 days of family residence. Hence the average length of stay among these 19 families was 147 days.

It should be noted that this average is skewed by the inclu of families who were in residence for only a few days. One fami was in residence for five days, another for 13, and yet another only a month. Eliminating these families reduces the total numb of days of families in treatment by 58 days but increases the average length of stay of each of the remaining 16 families to 1 days.[1] The range of length of stay in the program varies from f days to 10 months.

One last descriptive statistic will be offered. The increa urbanization of the NA population of the U. S. and Canada is evidenced in the tribal background of client heads-of-family.[2] over, the role of a city like Seattle as a port of entry for NA from quite a large area is portrayed.

Families	Tribes	Washington	Other
N = 26	18	11	7 (mostly Canadian

Summary of Characteristics of Residential Program Families

As the foregoing data indicate, the families which have bee

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[1] In these calculations a 30 day month was used.

[2] The population of NAs residing in or near urban areas rose fr 166,000 in 1960 to some 340,000 in 1970.

in residence at the ATFCP have been economically marginally an dependent. They have been poorly educated and possess few sal work skills. The majority have difficulties with alcohol, and managing their affairs when drinking. The majority of familie engaged in making the reservation-urban transition with the po that differences in norms of conduct and definitions of childh competencies may play a role in their difficulties with child separation. The vast majority of families have been headed by in various stages of separation or divorce from husbands.

These folks have been the target clientele of the ATFCP. operations of the program are described in the following chapt

CHAPTER IV

PROGRAM COMPONENTS

The ATFCP began operation as a wholly residential treatm facility. It soon became apparent, however, that the need o families in the area for assistance with foster care related other family difficulty far exceeded the limitations of the residential program in terms of available apartment units. order to reach as many NA families as possible, an outreach was developed in response to growing numbers of referrals af year 1974. Previous to that time, outreach activities were out by residential program staff which resulted in poor outr continuity due to the demands of the residential program cli

Over a period of time, then, the ATFCP developed two in linked program components: residential and outreach.

The Residential Components

The difficulties in establishing an appropriate mode of operation for the ATFCP have already been mentioned in Chapt The mode of operation described here reflects the last year half of program operation in which staff developed a method service delivery responsive to the needs and goals of the fa in residence during that period.

Over the course of the research and demonstration progr have been 26 separate families in residence. (Admissions nu due to the fact that two families were repeat admissions to residential program.) Intake procedures describe the proces

which eligibility was established.

A limited life history was taken on families interested in residence in the program. Full information was taken, whenever possible, concerning the situation which was responsible for the threat to the family's continuity, or had resulted in child separation in those cases requesting assistance with reconstituting their families. Another related intake operation was the development of a tentative treatment contract which specified the goals of the family in treatment. The treatment contract approach served two different functions:

1. It apprised the client-family of the mode of operation of the ATFCP.

2. It helped to specify goals of the client and suggested means by which the program staff could be of assistance in helping the family achieve their stated goals.

As should be obvious, there was no intent to have the initial treatment contract limit the range of areas in which staff and client could work should the client family be admitted.

Mutual agreement between client family and worker as to the terms of the treatment contract was a necessary pre-condition of final screening for program eligibility.[1] Final determination regarding the eligibility of a specific family was made in a staff meeting in which the specific case was reviewed and comparison to other available applicant families made. Selection of families was made on the basis of an assessment of the family's circumstances, including the following criteria:

1. There existed a threat to the family's ability to continue as a unit unless some sheltered living situation could be arranged.

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[1] This description applies only to planned, and planned-emergency intakes.

2. If children had been separated already, regaining custody could be difficult for the parent unless the parent was a participant in a therapeutic program with supervision available.

3. The family was amenable to a group living situation.

4. There was no evidence of severe behavioral difficulties (excluding alcohol related difficulties) or psychosis. This criteria was based on experience with two families in which the head of family was diagnosed as psychotic and whose presence in the program was extremely harmful to the other families.

5. Meeting the other eligibility criteria established for the program.

Based on staff agreement, the family was notified of their eligibility for the program. From that time steps were routinely taken to arrange for the orderly movement of families into the program (experience with the first client in the program in 1973 motivated the staff to extreme caution in admitting client families (see Chapter II).

In most cases relation of the family into a residence involved providing the family's new quarters with furnishings. Over time, furnishing apartment units became less of a problem since resident families could move into furnished apartment units vacated by former residents in the program. Most of the families entering the program came with few possessions other than clothing and some household items. The families were provided with various items, from the store of such items kept at the program, needed to setup a home. Arrangements were also made at the time of entry to help resident families with rental payments. The program rented the entire building at a fixed cost. Resident families were required to pay as much rent as possible but in all cases rents requested of clients fell below the actual cost of the apartment unit to the program.

During this period of entry the family was also apprised of the "house-rules" and told about various program activities.

House Rules

1. No drinking! Vilation will result in termination.
2. Curfew will be on individual basis. (Client should know what time is reasonable.)
3. Destruction of ATFCP property will result in payment.
4. Clients will be responsible for their own apartment and mailbox keys.
5. All clients will become involved in all ATFCP activities such as group sessions, outings and programs setup by their family worker.
6. Clients are responsible for cleanliness and upkeep of their apartment.
7. Pets will be allowed only if they are kept clean and quiet! No pets allowed in hallway. Cleint will be responsible for own pets.

These "house-rules" grew out of early program experience with the kinds of difficulties that developed among residents and staff of the program. Of all the house-rules the one concerning drinking was most difficult to enforce. While well intended by staff as a means of reinforcing the treatment obtained for the clients through the Seattle Indian Alcoholism Program, and as a means of clearly defining the consequences for drinking by residents, this rule still was commonly broken.

The breaking of house-rules No. 1 was endlessly problematic for staff. Since so many of the family heads came into the program for assistance around problems with alcohol, the staff realized that it was a bit unrealistic to expect the client to dry out as soon as he or she entered the doors of the program. As a consequence, infractions of the rule were tolerated repeatedly until the behavior of the indulging family member began to effect other families in

residence. As will be clear in the section on evaluation of the program, continued drinking was the basis for the termination of several families from the program.

Similarly rule No. 5 regarding participation in ATFCP activities was troublesome, since it, too, proved to be difficult to enforce.

As soon as the client family moved into the residence unit, a family worker was assigned to assist the family in obtaining necessary supportive services. In many cases there was a need for immediate medical attention. In other cases, legal assistance was required. As a program dependent on other community services to provide necessary service assistance, the ATFCP maintained liaison and coordination with several other programs. The major program with which such coordination was maintained were the Seattle Indian Center and its several sub-programs; the Indian Health Clinic, which was used for medical referrals; and the Seattle Indian Alcoholism Program. Such affiliations permitted client families to obtain needed services beyond the scope of the ATFCP staff to provide. Another common class of referrals were made in response to the desires expressed by several family heads for more education and/or job training. Although unsuccessful at finding jobs for adults interested in finding work, the staff was able, in several instances, to help clients arrange for job training and education, usually a GED program. The staff has also spent a great deal of time assisting family members to become acquainted with the variety of services available and, more importantly, helping clients to learn the methods of use of such services. Many of the families were in need of various services but were either unaware of them or uncertain of how to use them.

Residential Program Activites

Planned activities have played a major role in the development of the ATFCP. Such activities have varied from group sessions with mothers of families in residence to outing for resident families and staff using chartered buses. Attendance at ATFCP activities has bee extremely mixed, varying from faithful attendance by some persons to almost no attendance by others. Records of attendance at ATFCP activities have been extremely poorly kept but the following figures based on information available, describe the basic attendance patter

N = 26	Attenders	Non-Attenders	No Record
	8 adults (31%)	3 adults (12%)	7 (27%)

For those individuals whose records permit computing percentage of attended activities the following total percentage of attendance has been calculated:

N = 8 124 activities 55 attended = 44% attendance

As the available information indicates, attendance at ATFCP activities varied by individuals. Attempts to increase attendance at program functions have not met with great success.

As was true of the records on activity attendance, records of program activities were not systematically kept. The following events do, however, provide examples of kinds of activities that occurred through the planning of resident families and staff.

July 17, 1973	Picnic for resident families and staff in State Park.
August 30, 1973	Bus trip to Mount Rainer National Park.
January 26, 1974	Cultural trip to Neah Bay Indian community
February 21, 1974	Pot-luck dinner with resident's meeting following.

March 24, 1974	Rodeo at Seattle Center
August 14, 1974	Family planning meeting at ATFCP
August 21, 1974	Family planning workshop for residents at ATFCP

These and other activities provided a means by which the resident families and staff could learn to cooperate together toward the achievement of mutually agreed upon goals. In addition, such activities, especially the outings, gave at least some minimal opportunity for otherwise home-bound families to get out of their apartments and recreate.

It is important to appreciate the living circumstances of families within the ATFCP residential program to gain an adequate sense of the importance of outings and other activities for the resident families. In very few cases did families possess personal automobiles or other forms of transporation. In addition, financia constraints posed serious limits to the degree to which families could engage in family activity. For many families, opportunities to engage in social activities with other families in a new environ ment, such as a park unfamiliar to everyone except staff, were rare Due to these factors, self-report statements made by participating client families about such activities tend to be highly positive.

After several months of attempting to structure program activity to both relieve the boredom of client adults who otherwise might not have anything to do, and to provide educationally sound experiences, the program staff, in February of 1974, decided to instiute a weekly program of available activies:

Monday:	Beading and Costume Making-this choice was based on the interest of some clients in learning these traditonal skills, and the availability of other clients to teach these skills. Staff participated in these sessions as well as clients.

Tuesday:	Baking
Wednesday:	Alcohol Education Classes
Thursday:	Group Meeting and Potluck Dinner-this choice was based on the need to have a time for staff and residents to get together and plan program activities. A pot-luck format was chosen to encourage the spirit of mutual contribution toward a program function.
Friday:	Y.M.C.A. Family Swimming Night
Saturday:	Usual day for planned outings, which were planned the week before.
Sunday:	No Planned Activity.

These activities were scheduled for the evening, except for the Saturday outings. The intent of the program staff in developing this schedule of activites was to provide participating families with at least some activity during periods when staff would usually be gone for the day, and on weekends.

Although attendance was a problem, it was decided to continue these activities based on the positive feedback obtained from those who tended to participate regularly. As a consequence, this feature of the ATFCP has continued through the subsequent program period.

Worker-Client Interaction

As has been mentioned previously, the major form of staff treatment with clients has been supportive-directive counseling. As a means to document this form of worker intervention and its primary use by staff of the program, a random sample of some 25% of the residential case records was pulled. Using a two part definition of worker intervention the resulting data indicate that the overwhelming proportion of worker inputs were in the form of directives and supportive comments.

Analysis: Two categories were used

1. Clarification: discussions regarding feelings of guilt, anger or other affect states.

2. Directive-supportive:

   a. directive-making referrals, instruction in problem solving (modeling problem solving behaviors to the client) arranging with the client some activity;

   b. supportive-encouraging the client to undertake some activity, and reinforcing the client's problem-solving or planning behavior with praise or other verbal reinforcers.

In terms of the foregoing definitions worker activity can be summarized as:

Worker activity	Percent of total
Clarification	29
Direct-Supportive	71

The other aspects of worker activity are best illustrated by example. The following are four case examples written up by the program director for a quarterly report.

(In the following cases the ATFCP is referred to as the Native-American Community House, or NACH.)

CASE A

Mother, age 29, separated, Five children ages 2, 5, 6, 8 & 9

Referred, March 1974 from Children's Protective Service/Indian Hea

Service

Reason for Referral: Mrs. X and her children were in danger of both physical and emotional harm from her husband. The husband had allegedly abused one child causing bruising and bleeding and leaving him locked up in a small room. In addition, the husband while drunk, and in the presence of the children, had shot up the house with a hand gun while attempting to destroy the children's pictures which hung on the wall. The sheriff was called to the house but no action was taken against Mr. X. Mr. X was later visited by the sheriff's department and by a mental health center. Their assessment was that Mr. X was rational and no action was taken against him. Mrs. X, fearing for the safety of her children

made application to NACH.

Intake Assessment: Mrs. X has no income and the present situatic indicates her children have been subjected to emotional and physi harm associated with neglect. The family has chronic economic problems resulting in the shutting off of utilities, respossessic and inadequate school clothes for the children. The family had b subjected to frequent moves between Utah, the home of the father' family, and the local reservation. Mrs. X's frequent attempts to leave her husband ended in frustration due to her lack of resourc and child support. Mrs. X's emotional state is unstable and she has attempted suicide. She suffers from stress caused by her com plex problems and the burden of dealing with them alone.

Action Taken by NACH: March, 1974. Immediate intake and reside at the Community House.

Agencies mobilized to assist:

a. Seattle Indian Center -- provided emergency loan to Mrs for the purchase of food and clothing; legal services obtained a Restraining Order to protect the family from further abuse by the husband.

b. Indian Health Services -- provided mental health counse

c. Seattle Indian Health Board -- provided medical and den checkups for the family.

d. Seattle Indian Alcoholism Program -- although Mrs. X's drinking was not too heavy, SIAP was used to obtain job training through the Department of Vocational Rehabilit

e. Seattle Central Community College -- GED completion.

Participation Assessment: Mrs. X's situation has greatly improv during her first year of NACH involvement. Motivation was diffi at first. A general overall assessment is that Mrs. X's new-fou dependency has improved her self image which has made her a much stronger person. She is more verbal, takes better care of her children and is not so dependent on male companionship. She is able to function in an urban setting which was difficult for her first as the family had been raised on the reservation. The chi have adjusted to school and are assuming various responsibilitie NACH worked with Mrs. X in obtaining support services such as tr portation, furniture, clothing, school enrollment for the childr legal and medical referrals, GED. Counseling services centered around her dependency on a male figure, parenting, adjusting to her medical and legal problems, understanding her role as "head the household," and her responsibilities for protecting her chil Approximately 25 hours of legal services have been provided by t legal staff of the Seattle Indian Center to Mrs. X in dealing wi her legal problems.

Present Status: Mrs. X is still experiencing difficulty in foll through with responsibilities. She creates many situations from which she is unable to get out by herself and calls on NACH for assistance. NACH is cautious not to create dependency, but this a borderline case. The need is great for this family to be able call upon Indian organizations for help. However, she is gainin strength although she is still involved with men who are negativ to her. She receives counseling on a weekly basis in the area o family management and her ability to cope with arising situation She will require continuous psychiatric counseling. She is prot her children but still relies on the oldest to assume the mother role. This is another concern to the NACH staff.

CASE B

Mother, age 27, separated, two children ages 3 and 7 in fo care in white home. Referred, January 1974 by sister who was a resident. Admitted to NACH, February, 1974.

Reason for Referral: Mrs. Y had no income, no place to live, a chance of having her children returned to her unless she had an income and a suitable apartment or house. She had no means of porting her children to Seattle from Omak, where they were stay

Intake Assessment: Mrs. Y was concerned about the affects of t foster parents of her children. They were "too strict" and the oldest boy was expressing anger which further prompted the addi discipline of the foster parents. When Mrs. Y reacted against foster parents she was told by her caseworker that if she bothe them again she would be denied the right to see the children at

Action Taken by NACH: Mrs. Y was doing well with SIAP and was to school. NACH contacted DSHS (Omak) and the local officials began the process of having the children returned to Mrs. Y. P gress letters were requested by NACH from local agencies in ord decrease the time involved to have the children returned. Lett were sent to Omak DSHS and within a week arrangements had been with NACH to provide transportation for the return of the child to their mother. The experience of seeing this family reunited an unforgettable highlight to the NACH staff.

Participation Assessment: During Mrs. Y's stay at NACH there w not a lot of participation. She received counseling in the are of child management and was provided reassurance for her mainta ing sobriety. Her oldest boy had experienced some problems of jealousy of his younger brother and had reacted with negative actions such as bullying and breaking things. A program was de oped for the son which was designed to develop his self image feeling of being needed. This program was successful. Mrs. Y NACH in July, 1974.

Present Status: During her stay at NACH, Mrs. Y finished her attended and finished scretarial training, and became employed With the security of a job and independence for the first time

her life. Mrs. Y and her children have not taken their places a assests to society.

CASE C

Mother, age 25, separated, three children ages 2 months and 1-y

old twins. Twins in foster care.

Reason for Referral: The original apparent reason centered aro lack of resources, no income, marriage difficulties, desire to regain lost children, no possessions, lack of employment, feeli of isolation, and low self image.

Assessment: First assessment indicated no major difficulties, Z was a child abuser. Subsequent counseling sessions brought o deep angers about her life, her ability to parent, and her host toward her husband and herself. Mrs. Z came from a small villa in the northern part of Alaska. Living with alcoholic parents and other relatives, she began drinking at an early age. Her first move to North Dakota left her in a state of loneliness fo her family. She was drinking heavily and was left alone consta by her husband. Her feelings about her marriage were tradition "if you divorce, you go to hell." Mrs. Z's self image was poor "I'm ugly. I'm a failure in my marriage. I don't care." It s that Mrs. Z's NACH involvement was not producing many positive results. Different approaches were not effective. Her constan concern about her husband brought on anger, fear, and frustrati She became involved in LPN training but dropped out shortly bef graduation. She was proud and doing good work in her schooling could not relate it to her dealings with her own family. (What terrible transition Mrs. Z was going through. In her village s fed her baby by first chewing the food. Learning to use a fork knife, and spoon was a major task in her readjustment. All of her traditional beliefs: "the family is sacred; no divorce; Ma will help; husband will take care of me." were being denied her the urban setting in which she found herself. As she became mo independent, the traditional past always stood in the way: "I can't turn my husband out. Do not want people to think I am a mother.") Her anger centered on one twin. As the NACH staff b aware of Mrs. Z's emotional state (she was either very happy or very depressed) a referral was made to CPS. A caseworker who w extremely sensitive to Indian people and who could also provide the needed expertise to provide a court structure if needed, wa assigned to work with Mrs. Z. NACH feared that Mrs. Z's anger eventually result in harm to the one child. The children were beginning to show signs of emotional stress. Mrs. Z eventually relinquished custody of the twins. They have been adopted. Th baby remained in Mrs. Z's custody. There has been no harm done the baby.

Present Status: Mrs. Z is still involved with NACH. Through excellent work of the local CPS unit, she has been able to rel to her decision to place the twins for adoption. For a few mo there was no follow-up with Mrs. Z except through her case wor She is once again involved and has taken on a new, independent

role. NACH has constantly supported her in her decision to relinquish. She is much happier and has an improved self-image She still is experiencing guilt feelings about her husband, but she is better able to cope with it. NACH looks forward to her participation and sharing her experiences with other Native par during group meetings. "They (NACH residents) don't know how g they have it here. I'm going to tell them myself. I want to h someone else who is going through what I did."

CASE D

Mother, age 15, single, one infant child, age 15 months

Referred by Seattle Indian Alcoholism Program

Reason for Referral: Miss D is a young mother. There was con that, since she is so young that problems could arise in the area of CPS and she needed education in child care. Miss D wa to finish school and get some sort of income.

Intake Action: Because of her age, it was decided that Miss D her baby should be given NACH residency status. This was done September, 1974. At first she was not active in the programs provided, but constant encouragement was given.

Agencies mobilized to assist:

a. Indian Alternative School -- to obtain GED

b. DSHS (Rainer) -- for public assistance and medical ca

c. Children's Orthopedic Hospital -- for maternal and in care supplement for the baby.

d. Seattle Indian Health Clinic -- for mothering aids, c care training

Assessment: Miss D adjusted readily to her new role and respo bilities. At first she felt harassed by public health nurses. baby and a diaper rash and a burn on the leg which resulted in the filing of a CPS complaint. NACH requested a visit from CP discuss the concern. This resulted in a withdrawal of the com It was a major problem for Miss D to deal with CPS and the pub health nurses. NACH was able to arrange for an Indian nurse t work with Miss D. NACH staff worked with Miss D in the areas family management and child care.

Present Status: Miss D and her baby are doing very well and a preparing to move at the end of May, 1975. She is preparing f her GED. The baby is very healthy and happy. Miss D has sudd matured and is now speaking up and voicing her own opinions. D will be assigned a NACH non-resident counselor for follow-up

The foregoing examples provide a clear picture of the ki work that the staff of the residential program engaged in. B the cases were not selected at random they illustrate four of more successful cases in the treatment history of the ATFCP. to be presented in the section on treatment effectiveness wil vide a more objective view of the program's successes.

Child Care Services

From the inception of the ATFCP, one of its objectives w provide child-care services to resident families to permit th family adults to pursue activities pertinent to the achieveme their personal goals. The provision of child care services h an ongoing function of the ATFCP.

In the early months of the ATFCP operation, two position designated as child care worker positions whose primary funct to provide for child-supervision in the event of necessary pa absence and to ensure that the children of families in resid obtained necessary medical and dental care. All families en the ATFCP were required to have a physical examination at th Health Service Clinic to identify and remedy any medical pro Any medical attention required by children or adults during at the program was provided by the IHSC on an as-needed basi Systematic data were not kept on the number of such referral child medical treatment. The rate of "colds" and other resp ills among the children of families in residence was respons the majority of referrals for medical treatment. Many of th children had not received childhood immunization innoculatio in all cases, the parents were assisted to arrange for and f through on such medical service.

The high rate of unemployment among NA adults in reside the ATFCP obviated the need for a structured child care prog Rather, when adults had to attend meetings, or participate i ing programs arrangements were made with available staff or residential program family to care for the child(ren). Duri first six months of program operation, the child-care worker available for child care in the event that parents needed to their children. Structured play activity was encouraged amo the children in the program to permit them some form of coll recreation. Very early in the operation of the program, how the staff decided to develop a baby-sitting cooperative syst among the resident families.

Besides being an instigation to cooperative behavior a resident families, the baby-sitting cooperative served the function of providing a means by which parents could find c for their children when they wanted to go out in the evenin day-staff were available. Supervision of the baby-sitting tive was provided by the resident supervisor family. The a the resident supervisor family were available on evenings a ends to provide supervision of client-families taking care resident families' children or to provide such service them In several cases the availability of parent-surrogates led abuse of the service by participating resident families. I in which children were left with the baby-sitting family fo days are not uncommon in the records of the ATFCP, especial few families which had had a history of child abandonment. this problem, however, the system of child care which was d worked well. By July, 1974, due to staff turnover, no posi

were allocated for child-care workers specifically. The resident supervisor family assumed full responsibilities for supervising the child care system developed at the ATFCP. In only one case was there a need to seek external day care arrangements for children in the ATFCP. The mother of the children who was going to a community college training program felt that she should seek out such child care on her own. Arrangements were made with a local family operating a day-care service and the children were placed there twice a week.

The readiness of NA peoples to take children into their homes has received attention in many places. In the case of the ATFCP this tendency proved to be quite functional as families receiprocated child-care quite freely.

As the following data evidence, child-care services were made available through the staff and families at the ATFCP to a large number of children.

Year	1973	1974
Children	30	62
Families	11	19**

The Outreach Component

The outreach component of the ATFCP developed from the early casefinding and follow-up activities of the staff. Later there was more and more demand for services to families who could not be admitted to the program for reasons of eligibility or no available residential space. Because of the relatively small numbers of referrals being received, this function was shared among the staff of the residential program. With increasing referrals, however,

** Includes four families carried over from the 1973 program year to 1974

in mid-year 1974, a full time outreach worker was hired. More recently another full time outreach worker position was allocated to the outreach program.

The number of NA families in the area experiencing child-separation difficulties or other problems which could result in child separation far exceeded the limits of the residential program. Moreover, it was decided to attempt to assist such families through an active outreach program of home visits and referral-advocacy work. Supportive counseling and guidance were considered by staff to be of potential value to families often bewildered by the various demands by social agency personnel and lack of information regarding how to find resources and to use them in an urban environment. As a consequence, the work of the outreach program staff has been similar to the work of the residential program staff. That is, worker-outreach client contact consisted mostly of the workers sharing information with the client regarding the function of the child protective service agencies and other service agencies. Directive counseling was provided to suggest means by which the family could remedy the situation leading to CPS complaints. For many of the outreach clients the demands of social agency personnel were quite confusing. Demands to maintain sobriety, to find employment, to guarantee that children were not truant, to maintain a home environment acceptable to caseworkers, and so forth, appear quite often as examples of the kinds of demands being placed upon outreach clients. The activities of the outreach staff complemented the needs of the clients. The families were typically provided with referral information and helped through the process of utilizing resources in cases where assistance was necessary. Clients

also assisted to learn household management skills by outreach staff with the hope that such changes would result in alleviation of the complaint situation in some cases. The supportive function of the outreach staff paralleled the work of staff in the residential program. Many families were reluctant to use available services out of fear resulting from past experiences or ignorance of procedure. In these cases the outreach worker's primary function was to assist the family members to get to the appropriate service agency and to act as social brokers, advocates and supportive personnel.

Outreach Client Descriptive Information

The data for the families served by the outreach staff are presented here in summary form. Because of the large number of families served by the outreach staff a narrative summary will be provided.

Alcohol-related difficulties accounted for the bulk of outreach referrals. Eviction due to drinking was a common reason for referral since it resulted in a housing crisis. Complaints that parents left younger children in the care of the oldest child were common. Foster care placements were common. For 105 children for whom information is available, from 1973 outreach work, some 55 had already been separated from their natural parents.

Among the most common stated needs of the referred outreach cases which emerged from discussions with referring workers were.[1]

1. The need for a structured living situation
2. Alcohol management help

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[1] These represent the families' needs as viewed by caseworkers when such personnel were the referring agents. Many outreach clients were self or relative referrals.

3. Home-making skills
4. Supervision in child care
5. Medical care for children
6. Adequate housing

In regard to housing, most of the families in the outreach caseload were transients in the City, living in hotels and motels on a month basis, oftentimes leaving the premises when rents became due. Visits to families living in single rooms were quite common. In most of these cases a single room was all the family could afford to rent.

Many of the families were headed by single parents, mostly women. In no known outreach cases were family adults employed. Few of the families in the outreach caseload had adult-heads who had completed high school. For most, the average education was considerably less.

Among the difficulties most commonly reported by outreach clients were:

1. Alcohol management-problems resulting from binge drinking
2. Loneliness due to the lack of friends or kin in the urban environment
3. No income- a minority of outreach caseload families were receiving public welfare.
4. Being behind in rental payments--having housing problems
5. In need of medical attention for self or children
6. Legal problems

With few exceptions, the families reached by the outreach program staff are descriptively similar to those who have been in residence in the ATFCP. The majority were poor, unemployed, poorly educated, in dire need of survival information to cope

in the urban environment. A majority were headed by single women. The greatest differences based on impressions gathered by outreach staff has been that the outreach families were much more transient. This may be a function of the large number of outreach cases which were not receiving public welfare support monies. Although families are hard put to survive on public welfare benefits, for outreach clients the lack of even these minimal support monies militated against the family establishing even some temporary housing.

Evaluation of the Outreach Program

Data collection problems within the residential component were greatly exaggerated in the outreach program. The maintenance of outreach program intake and progress records have been extremely variable. Unfortunately there has been little systematic follow-up work done which precludes drawing any conclusions regarding the effectiveness of the outreach program in assisting NA families to avert child separation or regain custody of separated children.

Available information does describe the number of clients seen by outreach program staff. Of some 132 family and individual referrals received in the two year period-1973-'74, 408 individuals were involved.

1973		1974	
Families	Total No. Individuals	Families	Total No. Indiv
51	158	81	249

Of the total No. of referrals outreach services were provided to:

1973		1974	
Families	Total No. Children	Families	Total No. Chil
32	80	64	145

These data were obtained from available records which contain relevant information. Since there has been a problem in maintainin adequate case records these numbers may contain a sizeable error. If so, given the data problems, they probably under-represent the number of children and families served by outreach staff.

Due to the large array of problems faced by client families in the outreach program caseload and the difficulty of displaying both problems and worker interventions, it is probably best to offer some examples of the outreach caseload and the types of inte ventions which were necessary.

The following examples were drawn at random to avoid biasing the selection of cases for description.

Total N for the active outreach cases = 96 families

Sample cases number ten which is approximately a ten percent sample of active outreach cases.

Case 1. Twenty-one year old woman, never married. Referred by he parole officer. Mother of one child. She had just been released from a women's prison at the time of referral to the ATFCP. The client came with a history of alcohol and drug abuse; she was concerned about child abuse to her child when drinking and was afraid that she would lose the child permanently.

Interventions: Client referred to the SIAP, enrolled in Indian history courses. An SIAP counselor agreed to make home visits. According to available information the clie is staying away from alcohol and has a part-time job.

Case 2. Single mother with three children. Referred to the ATFCP by the Indian Health Board. Mother drinking heavily; according to referral source information the youngest child (six months) almost died of malnutrition resulting from neglect.

Interventions: Home visits repeatedly attempted. No conta made.

Case 3. Couple, male head of household aged 56; two children not living at home. Children are reported to be chronically truant from school. Both parents have serious difficulti

with drinking; reports of sexual abuse of children when they were living at home.

Interventions: Home visits repeatedly attempted. No contact made. Contact established. Referral made to the SIAP and to the Indian Heritage Program. No follow-up information available.

Case 4. Single woman with two children. Referred by a friend. Mother having legal difficulties arising from shoplifting. Mother pregnant and in need of pre-natal care. Mother drinks heavily. Family receives public welfare support. Two children are in a receiving home; three previous child separations due to neglect-abandonment due to drinking. CPS filing for deprivation.

Interventions: Home visits attempted, no contact establis

Case 5. Single woman with a small baby (4 mos. old). Baby reporte by mother to have heart trouble and in need of medical attention. Mother's boyfriend beat up baby which was the basis for CPS complaint resulting in referral to the ATFCP Both mother and boyfriend drink heavily.

Interventions: Couple referred to SIAP. Child obtained medical examination, mother instructed in the arrangement of regular medical checkups for the child. No follow-up.

Case 6. Single woman with two children facing eviction due to babi crying at night. Mother unemployed, desirous of job train ing. Children in need of medical attention. Mother in ne of legal assistance to deal with the eviction problem.

Interventions: Client referred to the Family Services Program of the Seattle Indian Center for emergency food. Children taken to the Indian Health Service Clinic for medical attention. Referral made to the Legal Services Program of the Seattle Indian Center. No follow-up.

Case 7. Widowed woman with two children. Has had a psychiatric history of some 15 years. Reported diagnosis of paranoid schizophrenia. Husband committed suicide last year. Her daughter is reported to have attempted to kill her mother. Client was a B.I.A. counselor earlier in life.

Interventions: Client referred to a professional counselo with the Indian Health Service. No follow-up.

Case 8. Single woman with two children. Separated from her husba living in an apartment with no furniture but a few chairs. Wants to place her daughter in foster care. Her son is residing in California with his father.

Intervention: Worker assisted client to fill out work applications, arranged for some furniture to be provided. Arranged for the daughter to be sent to her father in California until her mother could decide regarding ability to keep the child. No follow-up.

Case 9. Married woman, paralyzed from the waist down. Terminated from public welfare due to being the recipient of Native Land Claims Settlement monies from Alaska. Client depres over circumstances of her life.

Intervention: Client provided transportation and advocac assistance at the Seattle Housing Authority for a subsidized living unit. Welfare claims monies had long since been spent. Worker provided counseling around need for regular medical attention and how to arrange appointments. At last report client and children are living in a new apartment and are receiving public welfare support.

Case 10. Single woman with three children. Mother pregnant and drinking heavily. Possible child abuse. No record of referral source.

Intervention: Home visits attempted. No contact establi

The cases reported above reflect quite faithfully the kinds o problems outreach staff have been called upon to manage. More importantly the cases decribed portray the types of worker interventions which the outreach staff have found most efficient. Brie stated, the interventions can be described as home visits coupled with directive-supportive counseling with a concrete problem-solving emphasis including referrals to appropriate agencies. Whe referrals were made, every attempt was made to provide transportation, support when the client was dealing with an unfamiliar service agency, and in arranging for necessary basics such as food and clothing.

Of the 96 from which these examples were selected, 30 cases indicate no recorded contact between referred family and outreach worker. In others there is no information as to the types of service that were arranged or provided the family. For the remai

cases the above examples provide a faithful protrayal of outreach program clients and worker interventions. Given the unfamiliarity of many of the outreach families with resources available in the urban environment, the staff of the outreach program can be assumed to have had some beneficial effect in terms of the functioning level of outreach families.

Measures of Treatment Effectiveness

The major outcome criterion for evaluating the effects of the residential program was the success of the program in assisting the client-families to avert child separation. Due to the large number of families which had already had children or a child removed, in many cases reconstitution of the family was necessary first step.

Families	ATFCP-precondition of children being returned		Children with
	Children Returned - Not Returned		
26	16 families*	2 families	9 families
	49 children	3 children	32 children

Other Measures of Treatment Effectiveness

Because much of the work of the residential treatment staff centered on familiarizing the client family adults with available services and in the means of using such services, the number of referrals made relative to the goals specified by the clients h

* One family had some children placed, and some with the family at the time of admission. As a consequence one family is cou twice; in both returned and children with parent categories.

served as another measure of treatment outcome. The following descriptive information provides a summary of the services prov to client families while they were in residence at the ATFCP. all cases there was intensive one-to-one individual work with f adults to assist them in achieving the families' goals.

Follow-up information is derived from the most recent follow-up in February and March of 1975. In those cases where follow up information is not available, it can be assumed that previous attempts at follow-up have not been successful. Because of the mobility patterns of NA families in this urban area and the pro of families becoming "lost" in the public welfare system, sever families remain unaccounted for in terms of follow-up informati In those cases where any information regarding the status of th family, the last information available is given.

Services Provided by the Residential Program

Family	Goals	Services Provided	Outcome
1.	regain custody of child help with hallucinations problem with drinking	Alcohol treatment* health-care visitations arranged	No known
2.	problem with drinking and drugs	alcohol treatment pre-natal care employment counseling	client ing chi employe
3.	problem with drinking (husband only) child neglect	alcohol treatment marital counseling child-management counseling	child p husband B. C. longer Regaine child.
4.	problem with drinking / completion of education	alcohol treatment marital counseling children returned	maintai in Cana

Family	Goals	Services Provided	Outcome (
5.	problem with drinking & drugs	alcohol treatment marital counseling welfare advocacy children returned	children to abando current a unknown
6.	problem with drinking, husband abused her, regain custody of children	alcohol treatment legal assistance welfare advocacy children returned	maintaini living in
7.	problem w/drinking / boyfriend abuse / children needed medical attention / regain custody of sep. children	alcohol treatment medical treatment for children legal assistance* children returned	children Canada wi mother / up
8.	Problem w/drinking abandonment of children / no income / regain custody / medical attention	alcohol treatment medical care welfare advocacy children returned	children by Alaska Children'
9.	Family & marital counseling	counseling w/ family	family li area / ma child.
10.	problem w/alcohol assistance w/ anxiety / regain custody of children	alcohol treatment arrangement made w/ a M.H. counselor, medications prescribed / children returned	abandoned regained maintaini family wo GED
11.	marital counseling career planning regain custody of children no income	marital counseling assisted to complete GED / children returned / welfare advocacy.	oldest ch adopted taining youngest
12.	problem with alcohol / legal assistance re: divorce / prevent child separation career planning	alcohol treatment legal assistance - divorce obtained assistance in entering a job training program	client m friend / job trai taining in Alask

Family	Goals	Services	Outcome
13.	problem w/alcohol medical care / pre- vent child sep.	alcohol treatment medical treatment	maintai family area
14.	problem w/alcohol legal assistance health care- medical assistance career planning prevent child sep.	alcohol treatment medical treatment legal assistance welfare advocacy job training	maintai family
15.	problem w/alcohol medical assistance regain custody of children	alcohol treatment medical treatment children returned	maintai maintai plannin marriéd current
16.	problem w/alcohol marital difficulties regain custody medical care for children	alcohol treatment medical assistance children returned legal assistance	childre tempora sister. residen ment fo
17.	problem with drink- ing / problems w/ husband & boyfriends prevent child sep.	alcohol treatment marital and conjugal counseling/assisted in referring boy- friend to an alcohol treatment program	family custody boyfrie residen progra
18.	problem w/ alcohol legal assistance medical assistance arrange visitation regain custody	alcohol treatment legal assistance medical care visitations arranged children returned	child foster client of the
19.	problem w/ alcohol legal assistance medical assistance regain custody of children	alcohol treatment legal assistance medical treatment	no curr at las family tainin
20.	marital problems father's behavior toward female children was major factor in family coming to the AT ATFCP prevent child sep.	marital counseling employment-assisted client to find work husband committed- self to sexual offender program	family after treatm

Family	Goals	Services	Outcome
21.	problem w/alcohol health care for children regain custody of children	alcohol treatment medical assistance children returned	children subsequen family le ATFCP. returned. report - together
22.	problem w/drinking abandonment of children / medical care for children regain custody	alcohol treatment medical care children returned	abandoned while at Since the have been Mother is GED.
23	problem w/drinking marital problems career planning regain custody	husband referred to alcohol treatment marital counseling Wife obtaining GED Children returned	coupled to divor refused treatmen still to
24.	problem w/alcohol conjugal problems regain custody of children	alcohol treatment marital counseling children returned	children after le ATFCP. placemen
25.	problem with alcohol regain custody of children legal assistance	alcohol treatment children returned legal assistance	family l client's in Canad maintain

Evaluation of the ATFCP's success at preventing child se
tion and, as was common, re-uniting families which had alread
one or several children separated and then assisting the fami
avert further child separation, indicates that the ATFCP was
assist some 69% of client families to remain together as a fa
unit. Lack of contrast families, acting as a control group,
obviously weakens any statement that can be made regarding th
of the ATFCP participation in averting further child separati
Similarly, due to the lack of an adequate interval between cl
families' departure from the ATFCP and the follow up, the lon
effects of the client families' participation in the ATFCP ca
be known at this time.

Evaluation of the supportive work done by the ATFCP staf
reinforcing the treatment for alcohol problems obtained trhou
the referral of client families to the Seattle Indian Alcohol
Program is difficult to provide given the lack of rate measur
of client drinking.

Information regarding termination of client families pro
a useful profile the drinking behaviors of client family mem
since in many cases continued drinking was the basis for ter
tion.

Terminations fall into three categories:

Planned termination: The ATFCP had outlived its useful
based on client head of household
report or the client and staff in
sultation had agreed that termina
was desirable due to the achievem
of the client's goals.

Client terminated: The client decided that further r
in the ATFCP was not in their bes
and made the termination decision

Program termination: The client family was terminated due to continued infraction of ATFCP rules of conduct for resident families and/or were not seen as actively participating in program activities. In all these cases continued drinking played a role in the infraction of program rule's of conduct.

Number of termination by category: N = 26 families

Planned termination	Client terminated	Program terminated
11 (43%)	3 (12%)	12 (46%)

The number of terminations due to rule infraction related to continued alcohol-abuse, to the degree that the drinking behavior effected other members of the ATFCP, indicates that in at least 46% of terminations, alcohol treatment had not been successful using the criteria of abstinence or controlled drinking as indicators of success. Moreover, drinking at time of termination is not precluded by categorization into the other two categories. Rather, in only six cases is there indication, and that based only on client self-report, that drinking is either not a problem or is controlled. For those six families, three reported that alcohol was not a problem at the time of entry. Staff observations during those families residence at the ATFCP verified that self-evaluation. In the final analysis, then, only three adults for whom alcohol management was a problem at time of entry seem to have been assisted by the combined efforts of the ATFCP staff working in tandem with the staff of the SIAP.[1]

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[1] It should be noted that the attendance of many of the client adults at SIAP meetings was sporadic and discontinous which may have militated against the treatment programs of that community service having any significant effect.

Drinking at the time of termination	Not drinking at the time of termination & follow-up contact
20 family heads = 77%	6 family heads = 23%

Several family heads, for whom drinking was a problem at time of admission, evidence varying periods of sobriety during their residence at the program. The lack of rate information regarding the type of drinking at termination is troublesome for it dictates against drawing any conclusions regarding possible changes in management of alcohol among drinking clients. Similarly, as was mentioned on page 65, self-reports indicating that drinking was either not a problem or was being controlled, do not necessarily mean that other terminated clients for whom drinking was a problem at time of entry are persisting in their old drinking patterns or are drinking at all. Unfortunately the data available does not permit conclusive statements in this area. What is known, is that six family heads report drinking as being no longer a problem.

One Final "Measure" of Treatment Effectiveness May be of Some Value

In three know instances parent(s) left their children in the care of families or staff at the ATFCP under conditions which warranted the scaff of the program filing a CPS complaint. In two instances the families were in residence for a lengthy period of time and the program assisted these families in regaining custody of their children. In other instance, the program also assisted the parent to regain custody but the mother left her family with no care arranged only a few days after moving into the program. This mother has subsequently regained custody of her children and is working on a GED and is living independently in an apartment. In two cases the families still are separated.

In these three cases the program was clearly unsuccessful in assisting the family heads to arrange care and supervision children before leaving them for a period of time. In the latter case, however, the briefness of stay in the program worked against such treatment even beginning.

The range of services arranged for or provided, during the resident families' stay at the program, listed in the summary chart of services provided, need to be expanded to allow adequate detail regarding the needs of the participating families. In addition to arranging for medical and legal needs, families were assisted to understand the workings of a complex, urban bureaucratized environment. The application process in seeking public welfare support were oftentimes both frightening and bewildering to family heads. Many families received little or no medical care, due to the lack of information regarding the availability of such service. Moreover, for the majority of families medical care was out of the question unless free services could be found and utilized. These kinds of difficulty are hardly the sole property of Native Americans. Rather, they are characteristic of any immigrant population unfamiliar with a new environment. And yet for Native Americans, who are hardly immigrant to this land, the problem of people not knowing what their rights are and where to find resources, seems particularly tragic. Were it not for the many NA community services in Seattle, to which the staff of the ATFCP repeatedly turned for help, the problem would be far worse.

For the families which have been in residence in the ATFCP, every attempt has been made to help the family gain the basic necessities of life. Family heads were taken routinely to local food-banks when the family was in need. The program itself attempted to always have some canned goods on hand for emergencies. Clothes donated from various sources were made available to families. Through these means the staff of the ATFCP attempted to meet the very basic needs of the extremely poor, and displaced families who were the program's clientele.

The long term value of such service provision is unknown in terms of its effects on family functioning. As a proximate measure, the provision of such services must be seen in a positive light for it permitted at least 26 Native American families relief, for a while, from the day-to-day deprivations of being both poor and alone in a laree city. It remains to be seen whether or not the families which have participated in the ATFCP are better able to cope with the ongoing struggle of being both poor and Native American in a society which has little use for either. Only repeated demonstration projects such as the ATFCP can answer the question of long term value to participating clients.

CHAPTER V

PROGRAM COSTS

Mode of Calculating Program Costs

Because of the start-up difficulties mentioned in Chapter II, the ATFCP did not admit its first client until January, 1973. As a consequence, cost information related to computing costs per unit served are provided for calendar years 1973 and 1974 only. Because data available from the grantee of the ATFCP is broken down on a fiscal year basis, the liberty has been taken of generalizing these fiscal year expenditures to the appropriate calendar year. This has permitted costs per-calendar year to be calculated.

The following expenditure figures assume roughly a 50/50 consumption of program funds between the residential and outreach components of the ATFCP. Even in the period when the outreach staff was not formalized by having its own designation as a program component, staff of the residential program acted, at least 50 per cent workload, as outreach staff. With the formalization of the program in mid-1974 the outreach program has had its own staff.

Expenditures are detailed only for the residential component. Because of the use of the 50/50 breakdown costs of the outreach program are obviously the remainder of funds when operating costs of the residential program are subtracted from the total operating budget.

Staffing and Other Operating Costs

Staffing Cost	1973	1974
Total	$29,972.16	$36,157.41[1]
Share to residential component	50%	50%
Share to outreach component	50%	50%
Staffing costs of the residential program	$14,986.08	$18,078.71
Other		
Rental facility	$ 6,863.01	$ 5,257.29
Total (share to residential program = 100%)	$ 6,863.01	$ 5,257.29
Supplies		
Total	$ 1,288.75	$ 426.81
Share to residential program	50%	50%
Cost	$ 644.38	$ 213.47
Consultation Services		
Total	$ 5,517.00	$ 1,328.24
Share to residential program	50%	50%
Cost	$ 2,758.50	$ 664.12
Travel		
Total	$ 2,041.22	$ 743.59
Share to residential program	50%	50%
Cost	$ 1,020.61	$ 371.80

[1] Indirect charges in the amount of $12,414.58 were paid to the Sea Indian Center. Those monies are added here as staffing costs; in 1974 only.

Equipment		
Total	$ 748.07	$ 250.88
Share to residential program	50%	50%
Cost	$ 347.04	$ 125.44
Office Expenses		
Total	$ 2,024.23	$ 824.59
Share to residential program	50%	50%
Cost	$ 1,012.12	$ 412.30
Other		
Total	$ 472.79	$ -0-
Share to residential program	50%	-0-
Cost	$ 228.90	-0-
Total cost of operating the residential program	$27,887.64	$25,535.36
Total cost of operating the outreach program	$19,179.59	$15,944.02

These cost figures were taken from computer printouts made available by the accounting office of the Seattle Indian Center.

The following section present a per-unit cost breakdown in terms of clients served by the ATFCP both in its outreach and residential components.

COSTS OF THE RESIDENTIAL PROGRAM

The following costs are given in terms of per-month costs per child to permit comparison with DSHS data on foster care costs. Months-in-residence per child has been calculated by multiplying the number of months in residence of a mily by the number of children in the family. Unfortunately, due to the lack of information available it is not possible to derive an over-time cost of foster

care. Such a cost figure would allow comparison between the costs per child of services received at the ATFCP as a deterrent to foster care with over-time costs of foster care for a sample of youngsters. Because length of stay information is not available regarding children in the Statewide system there can be no such comparison made in this cost analysis.

Projected costs of foster care placement of NA children can only be inferred from the data reported in Chapter I of this report on serial placements of NA children in foster care. The inference is that the majority of NA children who are placed remain in foster care for extended periods of time. The ability of a program such as the ATFCP to reconstitute families or to maintain families in th face of possible child separation must be linked, then, to a long term saving of public funds if the effects of the program on its clientele proved to be long lived. Available follow-up information suggests that for some 69 per cent of families which have been in treatment at the ATFCP this is the case, at least in the short run Long-term follow-up will supply the only resolution possible for this question.

1973-Costs of the Residential Program:	$27,887.64
147 months of child treatment costs per child per month	$ 189.71
1974-Costs of the Residential Program:	$25,535.36
203 months of child treatment costs per child per month	$ 125.79

The following cost figures for the residential program are based on total individual months in treatment--<u>includes parents as well as children</u>.

1973-Costs of the Residential Program:	$27,887.64
210 months of individual treatment costs per individual per month	$ 132.80
1974-Costs of the Residential Program:	$25,535.36
269 months of individual treatment costs per individual per month	-0- $ 94.93

Comparison cost of foster care placements of children in King County[1]

Month	Year	Total Expended	No. of Children	Cost
January	1974	$170,801	1,182	$144
February	1974	$138,103	1,127	$122
March	1974	$137,911	1,180	$116

Average cost per month of a child in foster care in in King County: $127.51

Per Child/month (King County)	ATFCP Per Child/Mo.	ATFCP Per Indiv/
$127.51	$189.71	$132.80
	$125.79	$ 94.93

As the above data indicate in program year 1973, the average of service per month-per child was significantly higher than cost foster care placement in King County. However it should be noted in 1973, due to start-up problems of obtaining referrals there we fewer resident families and due to eligibility problems a few of families did not have children with them while in residence.

Comparison between 1973 costs per child month in treatment 1974 indicates a significant reduction in cost. This is due to increased number of children in residence and a quicker rate of turnover.

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[1] From Department of Social and Health Services monthly reports.

Costs of the Outreach Program

The following figures describe the number of referrals mad to the outreach program and the number of such referrals which were assigned outreach workers and became part of the "active-outreach" caseload. Calendar years 1973 and 1974 are represent

	1973	1974
All requests for outreach services	51	81
Number of individuals represented in requests for services	158	294
Number of families assigned outreach worker	32	64
Number of children in families assigned outreach worker	80	145

Operating Costs of the Outreach Program	1973	1974
	$19,179.59	$15,
Cost per child of outreach service	$ 239.74	$
Cost per individual-includes all family members	$ 171.25	$

The decline in per-unit outreach program costs are directl related to the size of the outreach caseload. As more families benefited from outreach staff service (especially after mid-yea when an outreach worker was hired full-time) the cost per child individual served decreased significantly. No comparisons are offered to any other service costs due to the lack of any logic comparison services available.

Seen as a service which could act as a preventive to child separation resulting in serial/long term foster care, the costs outreach program may reflect, although seemingly high, a potent savings of public monies over the long haul.

CHAPTER VI

SUMMARY AND RECOMMENDATIONS

As the foregoing chapters indicate, any conclusions regardi the effectiveness of the modes of treatment developed at the ATI must be considered as quite tentative. The program has been suc ful in assisting client families to obtain much needed services commodities ranging from legal and medical assistance to foodstu and clothing. It has been successful in acquainting families, need of such information, with sources of service and assistanc both the Native American and non-Native American communities. program has been successful in explaining to participating fami how social agencies operate and what the families must do to av future child separations. There can be no doubt that at least few families will have profited from this kind of program servi Hopefully, family adults will have learned new methods of solvi old problems by observing the problem solving behaviors of staf persons. These acceomplishments obtain for both the residentia and outreach components of the ATFCP.

For at least a few families who may elect to stay in this area, the program may have played a critical role in reducing isolation by being a catalyst for the formation of enduring soc relationships among families who have been in residence and bet families and staff persons.

As a program, in the last year and a half, the operations ATFCP most closely resemble the settlement houses of some year As a research and demonstration project charged with developing innovative methods of treating Native American families in trou with child placement agencies or feeling the threat of child separation, the development of a treatment model which closely resembles a form of residential care which fell by the wayside years ago may appear to be regressive rather than innovative. Yet, considering the needs of the client families, the dusting and use of the settlement house model may, in fact, be most in tive with the target population. Especially considering the r urban transition of many of the families that have been in res

It is the lack of systematic data, resulting from the emp problems mentioned in Chapter III on measures which could more fidently predict the long term value of treatment at the ATFCP for resident families which force the evaluation conclusions o this report to be so tentative.

For the common goal of learning to manage alcohol, there only be a highly equivocal conclusion drawn. For the majority cases in which alcohol management was a problem at time of ent the data seem to indicate that it may still have been a proble program exit. The fact that so many families were terminated (i.e., 46%) for continued infraction of house-rules because of problems of self-management related to alcohol supplies furth evidence that the ATFCP in conjunction with the SIAP was large unsuccessful in assisting clients to manage alcohol. If one an optimistic viewpoint, such alcohol treatment may come to h

an effect on the drinking behaviors of at least a few of the families who were not drinking at time of departure from the With the lack of predictive information such a conclusion is obviously more of a hope than anything else.

Some families have learned enough through their involvem in the program that future child separations may be avoided. ability of the staff of the program to help many families reg children previously separated is an important first step in t development of ways by which this can be accomplished for mo Native Americans and other non-Native American parent(s) whos children have been removed. The number of families still re ing together at time of follow-up cannot, obviously, be take an unqualified evidence that some families were indeed helpe maintain their families. Although true for the period betwe program exit and follow-up, the interval has been too short necessarily assume that all these families will be together several years.

Although for a time the client families received intens assistance from staff in accomplishing their goals, still, w from the program, the families will have returned to the sam ment and living circumstances as they had when they came int program. The hope of the program has been that through its families will have been helped to be a little better prepare cope successfully with their problems in living.

Without the provision of routine education and job tra job placement the chances are quite high that the majority families which have participated in the program will remain

dependents.

Without effective treatment for alcohol problems, many family heads and younsters may never learn to manage alcoho some personnaly adjustive manner.

Without some added incentives built into educational p for Native American children in public schools with related to their parents, the future for some of the children who h in residence at the ATFCP looks bleak, for patterns of abse from school were evident among the older children in severa

The ATFCP program has been fortunate in attracting sta ing to expend the energy necessary to help the families in residence and also to work the punishing hours necessary to service to outreach clients. Because of the training and e that was possible through involvement with the program, at of the enduring legacies of the program to the Native Ameri community will be an increased pool of experienced and trai professional direct-service workers.

At least for a few years the existence of the ATFCP ha strated to Native Americans and non-Native Americans alike group of committed Native American persons and organizatio operate a program, in a very difficult area of service, whi fied the value of self-determination for Native American pe

RECOMMENDATIONS

In the case of the ATFCP it certainly seems true that can be learned from program mistakes and failures as succes experience of the ATFCP with its Native American clientele that any replication of the program with the same populati pate clearly the severity of the problem of alcohol manage

the majority of families experiencing difficulties with child separation. Based on the experience of the program it is recommended that:

1. Any future program similar to the ATFCP be centered around alcohol treatment program of known effectiveness.
2. Given the multi-problem nature of most of the families which have been in residence, a professional as well as paraprofessional staff be hired.
3. For purposes of cases monitoring and supervision such a program have a full-time professional case supervisor.
4. For purposes of developing measures and collecting appropriate data; either the staff must be trained in research methods or a full-time investigator with research skills must be on staff.
5. To assist family heads with job finding and training a component of any subsequent program should be funded to engage specifically in negotiating with training agencies and programs and in job-development and job-placing activities.
6. A sheltered living-residential program format be continued.
7. There be specific funds included in the operating costs of such a program for outreach-casefinding staff.
8. Such a program initially establish itself with administrative levels of local child placing agencies and seek out means of obtaining routine referrals from child placing agency personnel by administrative directives preceding the beginning of the program's operation.
9. Such a program have a component funded, staffed and licensed to act as a receiving home.
10. Such a program have built in resources for developing Native American foster-care homes.

11. Such a program develop, as an integral part of its operations, a component which is targeted specifically on assisting families who have had children placed regain custody and to work out long range plans with the family for means to retain custody.

Given these changes and additions the ATFCP model developed in Seattle has great promise for assisting families to maintain or regain custody of their children and to offer the kinds of services necessary to ensure to a great degree that families will be maintained over time. The empirical problems which have plagued the ATFCP are not insurmountable. With appropriate staff it should be possible to establish the kinds of measures of functioning and to collect data regarding progress toward those criterior behaviors which would permit client termination based on achievement of specified goals. Especially if treatment personnel are available to assist clients in overcoming such problems as alcohol abuse.

With these and other changes appropriate to a specific client group there appear to be no reason why an ATFCP-like program could not be established to good effect in other non-Native American communities which have a history of high rates of child separation with children becoming drifters in the system.

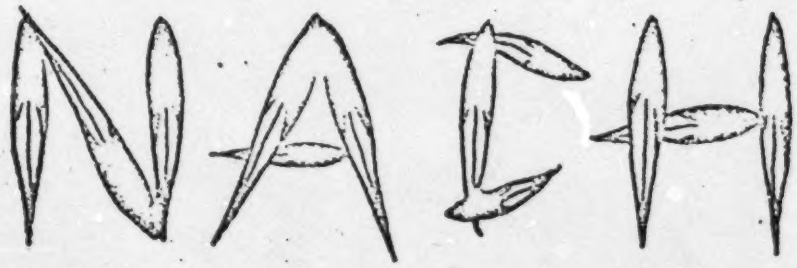
Both as a means to avert child separation and as a means of assisting families to regain custody of separated children the model developed at the ATFCP has enormous promise. The ATFCP as the first of its kind has had its share of difficulties, the lack of anything like it resulted in a pioneering effort which only sometimes was clear in its direction.

It is hoped that the experience of the ATFCP will be of value to other communities in setting up similar programs geared to prevent separation of children from their natural parents and/or to prevent temporary foster care from becoming unplanned long term care.

APPENDIX A

1. Original informational bulletin
2. A later informational bulletin
3. First intake form
4. Expanded intake form
5. Most recent intake form
6. Emergency intake form
7. Daily contact sheet
8. Behavior change project sheet
9. Client monthly evaluation
10. Child's health report form
11. Child's developmental status evaluation form
12. Release form for emergencies
13. Release of information form
14. DSHS authorization to release information form
15. ATFCP case recording guidelines

No.1



NATIVE AMERICAN COMMUNITY HOUSE
9044 53rd So. Apt. 287
Seattle, Washington
723-0463

The Native American Community House (NACH) is the first urban Indian program of its kind in the United States. It grew out of the concern of many members of the Seattle Indian community over the separation of Indian parents from their children in foster care. NACH is run by the Seattle Indian Center. It is set up to be an alternative to foster care for those Indian people who want it. In the summer of 1972, the Department of Health, Education, and Welfare funded this project through the Office of Child Development as a research and demonstration project.

NACH works on the notion that families can learn to handle their difficulties and, through such learning, stay together. We feel that most family problems can be worked out if the family has a strong will to stay together and that no family that wants to stay together should be splintered apart by foster care. NACH believes that family problems can be handled with help from the Indian community, the agencies of the Seattle Indian Center, and most importantly, through living in a residential setting which provides the opportunity to learn new ways of dealing with old troubles.

NACH is located in the south end of Seattle close to Lake Washington. The program runs an apartment building with several apartments. The offices take one apartment. The rest are for residents involved in the program. A qualified staff is available to help residents solve the problems which threaten to break up the family. They help organize the resident families for project activities as well as providing aid with problems in unemployment, drinking and drug use, job training, child care, and other areas where the family might feel the need for help. In addition to the regular staff, we have several volunteers from the Indian community who help where they can.

Because NACH is a residential program, we need the cooperation of the residents to make the program work. The program is open only to those Indian families who want to solve their problems which might result in loss of the children to foster care and who want to build a better future for their children.

To be eligible for NACH, a family must have at least one child under six years of age living at home. They must agree to stay in the program for at least three months, and they must want to enter and stay in the program of their own free will. Because NACH is meant to help people solve their <u>own</u> problems, we can help only those who want help. Without cooperation, we can do nothing. Because of this, we want all families to understand what NACH is about before entering the program.

Besides weekly meetings, classes, and activities, NACH offers individualized programs to help people who want to change their lives to do so. We believe that every person who comes to NACH is an individual of great worth and that fear and shame are often the individual's greatest enemy. We also believe that we can help.

No.2

NATIVE AMERICAN COMMUNITY HOUSE*
9044 53rd Ave. So.
Seattle, Wa. 98118
(206) 723-0463

Arlene Bolin (Clallam)
Project Director

Clay Anderson (Cree)
Resident Counselor

Pam Lamb (Nez Perce)
Pre-School Teacher

Virgil James (Yakima)
Outreach Supervisor

Betty John (Tlingit)
Outreach Counselor

Dear
KLA HOW YA - TILLICUM.....

The Native American Community House is a program for Indian families who are having problems and difficulties in "keeping together" or who just need someone to talk to.

NACH is a program run by the Indian people and for the Indian people. We feel that most family problems can be worked out if the family has a strong will to stay together and that no family that wants to stay together should be split apart by any one.

Virgil or Betty will be visiting some families in the near future and would like to stop and see you We would like to tell you more about the program and the different services available to you in the community.

If you have any questions at all, please do not hesitate to call us - that's what we're here for.

Sincerely,

Arlene Bolin

AB:dj

PERSONAL INFORMATION:

1. Education _____

2. Where living in the past years _____

3. Means of support in past three years _____

4. Parents place of residence and tribal affiliation:

_____

5. When did difficulties leading to the present problem begin?

6. Has the family been active in the Indian Community in Seattle?

7. Are the family's kinsmen living in Washington/Seattle or are the majority of kin living elsewhere?

8. Has the family been assigned a caseworker?
   a. If so who? _____
   b. How long? _____
   c. What office? _____
   d. How does family and caseworker get along?
      Does the family feel that the caseworker is working in their best interest?

9. Has the family had contact with Child Protective Services or the Police in the past?

No.4.

CASE NAME_____ Page 1

A. Caseworker Address Office Phone

B. Clients Name Age Sex Tribe (other)

1/

2/

C. Guardians Name Age Sex Tribe (other)

D. Children Name Age Sex Tribe (other)

1/

2/

3/

4/

5/

E. Educational Level of Parents

F. Marital History of Parents

G. Employment History of Parents

H. Other Source of Income and How Long

I. Urban/Reservation Residence and How Long

Childrens' Placement History

Childrens' Medical History

Major Treatment in NACH

Moved into NACH (date)_____

A. Referred TO:

B. Referred FROM:

2. Major Difficulties

3. Backround of Problems

4. Present Status

No. 5.

NATIVE AMERICAN COMMUNITY HOUSE
INTAKE FORM

DATE _____

FAMILY BACKGROUND

NAME _____ (SPOUSE) _____

ADDRESS _____

PREVIOUS ADDRESS _____

TELEPHONE NUMBER _____ EMERGENCY NUMBER _____

MARRIED ____ SEPERATED ____ DIVORCED ____ WIDOWED ____ OTHER ____ NAME _____

BIRTHDATE _____ SPOUSE _____

NUMBER OF CHILDREN _____ Ages _____ to _____

EDUCATION

Circle last grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED

College _____ Vocational _____ Other _____

What city did you go to school? _____

Boarding School _____ Reservation School _____ Private _____ Public _____

What are your reactions to your schooling? _____

_____

_____

Do ou have future schooling plans? _____

_____

_____

If you dropped out, what were your reasons? _____

_____

_____

_____

_____

Did the rest of your family finish school? Explain _____

_____

_____

_____

INCOME

BIA $_____

Per Capita $_____

Public Assistance $_____

Support $_____

Other $_____

What were your means of support during the last three years?_____

_____

If you had $25 to spend, what would you do?_____

_____

CHILDREN'S BACKGROUND

NAME	BIRTHDATE	AGE	M or F
1.			
2.			
3.			
4.			
5.			
6.			

Are all your children living with you? If no, explain._____

_____

_____

_____

Have your children been in foster care or placed with someone else before?

Explain. First time_____ # of previous times_____Explain_____

_____

_____

_____

_____

What were the events in your life that led up to having your family unit threatened?_____

_____

_____

_____

_____

_____

Has this situation eased or do you still feel that your family unity is being threatened? In what way?

What have you done to help your family out of this situation? Explain

What previous events have happened that are causing you problems now?

What do your children feel about being in a foster home and how have you reacted to this?

PERSONAL BACKGROUND

What kind of difficulties have you had in far past that are affecting you now?

Who were the people that have been supportive of you during this time of difficulties? In what way.

Were there persons that were detrimental to your life? How did they affect you? _____

What have been your experiences in relation to the courts, police and welfare?

What kind of childhood did you have? _____

Do you think this has affected your relationship to your own children? Explain

How did you get along with your parents, brothers and sisters? _____

How many brothers_____ sisters_____ Other family living with you_____

Did you get along with your school teachers, friends, etc. Explain_____

If you had three wishes, which would make your life easier, what would you want them to be?_____

1._____

2._____

3._____

Do you feel that excessive drinking has caused your family problems? Explain

_____

_____

_____

_____

_____

If so:

1. When did you start drinking_____
2. Do you drink alone or with friends_____
3. Does someone contribute to you starting to drink_____
4. How much do you drink in: One day_____ One week_____ One month_____

What kind of crowd do you run around with? and how do you feel that they have affected your family life?_____

_____

_____

_____

How do you see your future if the drinking continues?_____

_____

_____

_____

_____

How do you see your future, should you change your drinking pattern?_____

_____

_____

_____

What does the term "alcoholic problem" mean to you?_____

_____

_____

_____

_____

Did your parents, brothers and sisters drink? Explain_____

_____

_____

I'd like your opinion on drinking; what do you see as some of the major problems and reasons that our people are caught in this web of alcoholism? and what do see as a solution?_____

_____

_____

_____

_____

_____

I'd like you to give me three ideas in regards to what you feel are the most crucial problems of our people and how you would work to solve them.

1._____

_____

2. _____

_____

3._____

_____

WELFARE INFORMATION

How long have you been on welfare?_____Have you ever been taken off?_____Reason_____

Was your parents on welfare?_____Brothers & sisters?_____

Present Caseworkers name_____Telephone_____

Childrens caseworkers name_____Telephone_____

What could you do to get off welfare and how have you handled this?_____

_____

What difficulties have you had with welfare?_____

_____

List agencies that you have worked with:

AGENCY	PERSON	RELATIONSHIP	TELE. #

No.6

NATIVE AMERICAN COMMUNITY HOUSE - EMERGENCY INTAKE INFORMATION DATE:_____

Referring Person_____Tele #_____

Agency_____

Clients Name_____

Address:_____

Telephone #_____Tribal Affiliation_____

# of children_____Ages_____to_____

Problem:_____

Suggested Plan:_____

Referred to:_____

NACH Counselor:_____

Other Information:_____

Make two (2) copies - 1 file/ 1 for master file

No.7

CLIENT DAILY CONTACT

NAME & DATE

No.8.

NAME _____ PAGE# _____

DATE _____ MANAGER _____

PROJECT	BEHAVIORS RELATED TO PROJECT		TARGET BEHAVIOR	
	TOO MUCH	TOO LITTLE		

No.9.

Native American Community House

Client: _____

Client Monthly Evaluation

Areas	Satis.	Unsat.	Comments	Action to b taken
Attitude				
Personal Grooming				
Home Care				
Food Preparation				
Child Care				
Child discipline				
Recreational pursuits				
Motivation				
Housemeeting attendance				
Budgeting Skills				
Alcohol consumption				
Community involvement				
Verbal Communication with other clients				

Student Remarks:

Students Signature: _____ Family Workers Signature: _____

Date: _____

NATIVE AMERICAN COMMUNITY HOUSE

APARTMENT INSPECTION

A.	Outside Area	_____
B.	Living Room	_____
	Floors vacuumed	_____
	Walls cleaned	_____
	Windows clean	_____
	Furniture dusted	_____
	Upholstery clean	_____
C.	Kitchen	
	Burners Clean	_____
	Oven clean	_____
	Floors Clean	_____
	Trash Out	_____
	Refrigerator clean	_____
D.	Bathroom	
	Tub and sink clean	_____
	Floors clean	_____
	Toilet clean	_____
E.	Bedroom	
	Beds made	_____
	Dresser dusted	_____
	Closets neat	_____
	Floors clean	_____
	Walls clean	_____
	Clothes picked up	_____
F.	Overall apartment	_____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Apartment Total_____

Apartment Number_____

Date_____

Worker_____

Scoring: In each category you will receive from 0-5 points with 5 being the best score. If your total score drops below 80 points your apartment will be inspected daily until it imporves to above a score of 80 points.

No.10 INTERVIEWER_____

Health Report

Native American Community House

Creative Learning Program

Date_____

Child's Name_____Age_____Sex_____

Birthdate_____Tribe_____Telephone No._____

Name of Parent or Guardian_____

How is your child's health in general? Very good__Good__Fair__Poor_____

If health is fair or poor, what is the trouble?_____

_____

Is your child under a doctor's treatment at present? Yes__No__ If so, please give reason or condition._____

Is he(she) taking any medicines at present? Yes__No__ If so, please describe_____

Name of doctor, clinic where your child receives care_____

Does your child have regular well-child check-ups? Yes____No____Last_____

How long has it been since your child visited a doctor? 12 months_____

1-2 years_____ More than 2 years_____ Never_____

ILLNESSES

Which of the following diseases has he(she) had?

Chicken pox___ Scarlet Fever_____

Mumps_____ Baby measles_____

Tuberculosis___ chronic ear aches____

German measles_____ Exposure to T.B._____

Has the child ever been in the hospital? Yes__No__ If so, reason?_____

_____

Has child ever taken a poisonous or overdose of medicind? _____

List any allergies_____

IMMUNIZATIONS

How many baby shots(DPT) None___One___Two___Three___Four___Five_____

How many Polio shots None___One___Two___Three___ Polio Vaccine_____

Measles Vaccine Injection None___One___ Smallpox___Number_____

Scar present_____Tuberculosis Skin Test_____Yes___ No___ If yes was it positive_____negative_____

General Review of Systems

Has your child has any of the following health problems?:

Frequent fevers	Yes___	No___	Poor Appetite	Yes___	No___
Poor growth	Yes___	No___	Indigestion	Yes___	No___
Delicate health	Yes___	No___	Stomach pains	Yes___	No___
Tires easily	Yes___	No___	Diarrhea	Yes___	No___
Skin rashes	Yes___	No___	Constipation	Yes___	No___
Eczema	Yes___	No___	problems with bm	Yes___	No___
Swollen glands	Yes___	No___	Kidney problem	Yes___	No___
Trouble seeing and strains	Yes___	No___	Problem with bladder control	Yes___	No___
Wears glasses	Yes___	No___			
Crossed eyes	Yes___	No___	Bedwetting	Yes___	No___
Frequent earaches	Yes___	No___	painful urination	Yes___	No___
Very frequent colds	Yes___	No___	Urinates frequently	Yes___	No___
Nose bleeds	Yes___	No___	Hernia	Yes___	No___
Hay fever	Yes___	No___	Drinks too much water	Yes___	No___
Tooth problems	Yes___	No___	Diabetes	Yes___	No___
Throat or tonsil problems	Yes___	No___	Limping	Yes___	No___
Chest problems	Yes___	No___	Trouble walking	Yes___	No___
Pneumonia	Yes___	No___	Swollen joints	Yes___	No___
Bronchitis	Yes___	No___	Has injured head	Yes___	No___
Wheezing or asthma	Yes___	No___	Frequent headaches	Yes___	No___
Trouble breathing	Yes___	No___	Convulsions or seizures	Yes___	No___
Turns blue	Yes___	No___	Fainting spells	YYes___	No___
Heart Condition	Yes___	No___	Poor balance	Yes___	No___

No.11

ALTERNATIVE TO FOSTER CARE
CHILD'S DEVELOPMENTAL STATUS EVALUATION

Instructions: Check items which describe the child's usual behavior. Read each item carefully before making your decision.

Date:_____

Name of child:_____ Birthdate:_____

I. Child's relationships with family members

A. Child's response to being left with resident supervisor or other staff member:

Undisturbed _____ Anxious for parents return_____

Cries _____ Other_____

B. Childs response to brothers or sisters:

Seeks them out _____

Displays hostility _____

Ignores them _____

Describe relationship between children when they are playing together: _____

_____

_____

Feelings expressed about his family:_____

_____

_____

Other:_____

_____

_____

C. General appearance:

Well groomed _____

Inappropriate clothing for weather:_____

Often asks for food:_____

Has soiled face and hands:_____

Clothing dirty or torn:_____

II. Child's group relationships

A. Choice of companions

Name(s)_____

B. Child plays best when:

With one child:_____

In group:_____

By himself:_____

C. Relationship to adults:

Cooperative _____

Hostile _____

Fearful _____

Shy _____

Aggressive _____

Dependent _____

Demands extra attention _____

D. Character of participation

Able to share with playmates_____

Toys_____

Adult attention _____

Able to wait turn_____

Able to conform to group limits_____

Accepts his share of responsibility_____

Dominated other children_____

Bullies other children_____

Manipulates other children_____

Withdraws_____

Other comments:_____

_____

_____

E. Acceptance of Group routine:

Wants to be included_____

Interested in activities_____

Able to participate in group activities_____

III. Childs Activity Preference: Circle

Blocks
Balls
Dolls
Housekeeping equipment
Stories
Music
Art
Free Play
Organized games
Outdoor equipment
Other

IV. Child's Emotional Status

A. Prevalent Fears

None_____

Fear of_____

_____

Behavior when afraid (unusual)_____

_____

When attempts are made to comfort him,

He is easily distracted_____

Becomes more upset_____

B. Signs of emotional discomfort

None_____ Other_____

Thumb sucking_____ _____

Nail biting_____ _____

Eye blinking _____ _____

V. Child's behavior at meal time

A. Eating habits (circle)

Good appetite
Poor appetite
Plays with food
Needs encouragement to try unfamiliar foods
extremely hungry

B. Social behavior

Requires help with table manners
Distract other children by:
Loud talk
Teasing
Disruptive acts

Other_____

_____

VI. Child's behavior at nap time or bedtime (circle)

Goes to sleep quickly
Spends time getting ready
Takes toy to bed
Attempts to talk to other children

Length of sleeping time _____

Time children usually go to bed_____

Other (wets bed, etc.)_____

_____

_____

VII. Toilet Behavior

Tells when he has to go_____

Has accidents (state frequency)_____

Behavior when accidents occur_____

_____

Unusual behavior_____

_____

VIII. Observations of child's health (circle)

A. Good health
Subject to :
colds
headaches
stomach aches
blues
tires easily
whines or cries frequently

B. Limitations or defects

Hearing
sight
orthopedic
dental

IX. Child's physical characteristics (circle)

Active
Sedentary
Quick
Slow
Quiet
Very quiet
Other_____

_____

Coordination in comparison to other peers

Walking_____

Running_____

Climbing_____

Skipping_____

Hopping_____

Coloring_____

Drawing_____

Dressing_____

Shoe Tying_____

Other_____

_____

_____

X. Child's problem-solving behavior

Attempt to solve problems himself_____

Gives up easily_____

Seeks help from peers_____

Seeks help from adult_____

Other_____

_____

Xi. Attention Span

Describe during activity_____

_____

_____

Curiosity

Explores environment_____

Asks questions_____

Uses equipment in unusual ways_____

Awareness behaviors suggest:

_____

_____

_____

XII. Childs Intellectual Development

Distinguishes between large and small_____

Distinguishes long from short_____

Identifies: (circle)

Circle
Square
Rectangle

Knows names of colors_____

Chooses objects of correct color

Counts consecutively from one to_____

Chooses correct number of objects_____

Identifies number in text_____

Identifies words for numbers in text_____

Communicates through: Pulling_____

Gestures_____

Language_____

Talks: Seldom_____

Frequently_____

Disturbes other children_____

Enunciation: Speaks clearly_____

Baby talk_____

Own language_____

Mumbles_____

Whines_____

Speech impediment suspected_____

Other:_____

Language mastery:

Vocabulary:Limited_____Extensive_____Other_____

Expresses himself: Single words_____Phrases_____

Short sentences_____complex sentences__

Use of language: Converses with other children_____

Adults_____Other_____

Date evaluation completed:_____

Family workers name:_____

Use attachments to document suggested program for child.

No.12

ALTERNATIVE TO FOSTER CARE
CREATIVE LEARNING PROGRAM

RELEASE FORM FOR EMERGENCIES

I,_____ hereby authorize the staff
parent or guardian

of Native American Community House (Alternative to Foster Care)

to take any action needed in case of an emergency, to take any

of my children to the nearest Doctor, or Medical agency of my

choice.

Signed

_____
Parent or Guardian

Witness

_____
(NACH Staff Person)

DATE_____

NAME OF DOCTOR_____

PHONE NUMBER_____

ADDRESS_____

No.13

Native American Community House (Alternative to Foster Care)
Release of Information Form

In order for the Native American Community House to fulfill its obligations as an Office of Child Development Research and Demonstration Program it is necessary for us to have your help.

We need a release of information consent to use case records, client family files and any other information obtained during the families' stay at NACH for purposes of evaluating the effectiveness of the program in helping Indian families stay together and the effectiveness of the helping techniques used to assist Indian families in working out whatever difficulties that have brought them to NACH.

Your name and other personal information will of course remain confidential in any papers or articles that are written about Native American Community House.

I hereby authorize the staff of Native American Community House (Alternative to Foster Care) to utilize all clinical information for research and reporting purposes.

About_____who is myself, or of whom I am the parent or legally constituted guardian

_____(signature of person)

_____(witness)

No.14

Department of
Social and Health Services

AUTHORIZATION TO RELEASE INFORMATION

_____ Date

_____ Case Number

Complete to either authorize DPA to obtain information or release information.

I _____ Name, living at _____ Street/Box City State

hereby authorize _____ Person, Agency or Organization

to give information regarding _____

_____

to (an authorized representative of the Washington State Department of Social and

Health Services)(_____ Person, Agency or Organization)

_____ Signed

Information furnished _____ Date By _____ LO Employee

DSHS 14-12 (X) 10-72
14PA12 11-68
SF 5115

No.15

NATIVE AMERICAN COMMUNITY HOUSE DATE_____

Each form listed must be included in each clients file:

1. Intake form _____
2. Release Form (NACH) _____
3. Release Form (DSHS) _____
4. Social History (DSHS) _____
5. Social History (NACH) _____

CLIENTS NAME_____

CHILDRENS NAMES_____

_____

CASEWORKERS NAME_____

OFFICE NUMBER_____ ADDRESS_____

REFERRING AGENCY_____

COMMENTS:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX B
JOB DESCRIPTIONS

JOB DESCRIPTION

ALTERNATIVE TO FOSTER CARE - PROJECT DIRECTOR

DEFINITION

To provide overall coordination of the Native American Community House in regards to clients, counseling programs, activities, staffing, recordkeeping and Department of Social and Health Services liaison.

MAJOR DUTIES AND RESPONSIBILITIES

To provide continuous on a one-to-one basis to residents of Native American Community House;

to contact a number of State and Federal agencies to determine the feasibility of gaining alternative support for the ATFC Program;

to develop an onsite conference with these various agencies;

to continue liaison work with DSHS via referrals, attending Regional meetings and other as needed;

to prepare quarterly reports and report to element administrator;

to follow the approved work program for '74-'75. (attached)

to maintain caserecords and provide assessments;

is responsible for collection for data by funding source and for reports required by administrator;

is responsible for analyzing program progress and problems and reporting to element administrator.

MINIMUM REQUIREMENTS

Must be at least 21 years old;

Two years of college or equivalent of 2 years social program experience;

Knowledge of Washington State Public Assistant system;

Knowledge of N.W. Indian culture;

Knowledge of urban Indian adjustment problems;

Ability to maintain client records and program data.

Job Description

Resident Family Worker Alternative to Foster Care Program

This position is a "line staff" that is this position entails day to day work with client families carrying out through intensive contact the various treatment programs and adjunctive services necessary to move the family to adequate social functioning.

Supervision of this work role will obtain through contact with the Program Coordinator working in conjunction with the Program consultant.

Responsibilities

To establish a working relationship with client families through regular contact such that a peer relationship is possible;

to advise and give personal assistance in dealing with family and personal problems in daily living, the use of various institutional services and participation in program activities;

to provide adjunctive services when necessary and appropriate to the overall treatment program of individual clients, such as transportation, client advocacy and so on;

does agency and community liaison to ensure that the referral network continues to function. This will involve at least bi-monthly contact with the various agencies which supply the program with referrals;

Ability to develop and maintain case records, prepare reports, social summaries and other records;

ability to interpret needs of clients in reference to other agencies, programs and groups;

ability to exercise mature judgement and organize work.

Qualifications

Has had some experience in working with families and their children;

is familiar with the problems of Native Americans experiencing difficulties in urban adjustment;

Has high school diploma or GED quivalency;

Must have Washington State driver's licence and carry proper insurance.

Must be familiar with urban Indian adjustment problems and Native American culture.

SALARY: $600-750/month Hours: 12:30-9:00 Tuesday-Saturday

Job Description

FAMILY OUTREACH WORKER

Definition

To provide continuous follow-up and outreach work to former residents of Alternative to Foster Care Program.

Responsibilities

To provide follow-up work with families who have left ATFC to determine whether or not gains made during residence at ATFC have generalized to the natural environment in which the client is currently living;

does agency and community liaison to ensure that the referral network is continued for client after relocation;

to provide home visits when necessary.

Ability to interview, effectively, new clients, relatives, tribal people, agencies and other organizations to secure information to aid in developing program for client in regards to relocation to ATFC program;

ability to develop and maintain case records, prepare reports, social summaries and other records;

ability to interpret needs of clients in reference to other agencies, programs and groups;

ability to exercise mature judgement and organize work.

Qualifications

Has had some experience in working with families and children;

is familiar with the problems of Native Americans experiencing difficulties in urban adjustment;

has high school diploma or GED;

valid Washington State drivers license and carry proper insurance;

must be familiar with Native American culture;

SALARY RANGE: $500-750/month

Alternative to Foster Care Program 9044 53rd Ave. South - Seattle (206) 723-0463

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

JOB DESCRIPTION
FAMILY OUTREACH WORKER/COUNSELOR AIDE

Definition
To provide initial interviewing and outreach to and former clients of the Alternative to Foster Care Progra nd to assist staff with obtaining pertinent client records.

Responsibilities
To coordinate and provide interviews to new clients;

provides home visits when necessary;

ability to develop and maintain case records, prepare reports;

ability to interpret needs of clients in reference to other agenci

ability to exercise mature judgement and organize work.

Qualifications
Had had some experience in working with families and children;

is familier with the problems of Native Americans experiencing difficulties in urban adjustment;

has high school diploma, GED, or plans to complete in future;

valid Washington State drivers license and auto or plans to purcha in immediate future;

must be familier with Native American culture.

Salary Range:

Hours will be ~~12:00-8:00 P.M.~~ 10 — 6 Monday-Friday

Apply to: Alternative to Foster Care
9044 53rd Ave. S.
(206) 723-0463

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

JOB DESCRIPTION

Child Care Aide
Alternative to Foster Care

Description
Able to develop and implement a learning situation for children of Alternative to Foster Care Program;

Job Requirements and Abilities
Required to coordinate with staff at ATFC, in regards to development of child and relationship to counseling programs for family;

ability to document client files and set up files for children in regards to total family counseling program;

ability to develop curriculum and implement program;

ability to understand problems facing Native American people in an urban setting;

ability to set up nutritional program for children;

familiar with licensing requirements set forth by the State of Washington.

Qualifications
Must be familiar with Native American culture and arts;

Must be able to work with small children;

Must have a car with proper insurance;

Must have had previous experience in working with head start or other day care program.

Salary Range $400-500/month

Hours: 10:00-6:00 Monday through Friday

Reply to:

Arlene Bolin
Project Director
Alternative to Foster Care Program
9044 53rd Ave. S.
Seattle, Wa.
(206) 723-0463

WE ARE AN EQUAL OPPORTUNITY EMPLOYER